NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, AUGUST 6, 2020
2:00 P.M.

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

BOARD OF DIRECTORS

Isabel Becerra
Clayton Chau, M.D.
Supervisor Andrew Do
Victor Jordan
Supervisor Michelle Steel
Jackie Brodsky
Clayton Corwin
Mary Giammona, M.D.
J. Scott Schoeffel
Trieu Tran, M.D.
Supervisor Doug Chaffee, Alternate

INTERIM CHIEF EXECUTIVE OFFICER	CHIEF COUNSEL	CLERK OF THE BOARD
Richard Sanchez	Gary Crockett	Sharon Dwiers

This agenda contains a brief description of each item to be considered. Except as provided by law, no action shall be taken on any item not appearing on the agenda. To speak on an item, complete a Public Comment Request Form(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 materials are available for review at CalOptima, 505 City Parkway West, Orange, CA 92868, Monday-Friday, 8:00 a.m. – 5:00 p.m. These materials are also available online at www.caloptima.org. Board meeting audio is streamed live on the CalOptima website at www.caloptima.org.

To ensure public safety and compliance with emergency declarations and orders related to the COVID-19 pandemic, individuals are encouraged not to attend the meeting in person. As an alternative, members of the public may:

1) **Listen to the live audio at +1 (631) 992-3221 Access Code: 811-299-555 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/1498984401837590283**
3) **rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS
None.

MANAGEMENT REPORTS
1. Chief Executive Officer Report
   a. California State Budget Impact on Medi-Cal
   b. 1115 Waiver Extension Request
   c. Proposed Long-Term Care at Home Benefit
   d. COVID-19 Response
   e. Whole-Child Model Anniversary
   f. Meetings with Congressional Delegation
   g. Health Homes Program Phase 2
   h. Medi-Cal Rx Transition
   i. Medi-Cal Audit Draft Findings

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 June 4, 2020 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the April 23, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee Meeting; the April 28, 2020 Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee; the May 14, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee and the May 14, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

REPORT ITEMS
3. Consider Authorizing Execution of Amendments to the Primary Agreement with the California Department of Health Care Services

4. Consider Ratifying a Revised Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

5. Consider Approval of CalOptima Policy and Procedure GG.1352 Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21

6. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

7. Consider Approval of Modifications to CalOptima's Pharmacy Management Policies and Procedures

8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

9. Consider Authorizing Contract Model Changes for Physician-Hospital Consortium (PHC) Health Networks

10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

11. Consider Ratification of Temporary Operational Changes to the Program of All-Inclusive Care for the Elderly (PACE) Related to Coronavirus Pandemic

12. Consider Ratification of Amendment to Health Network Contract with Children's Hospital of Orange County and Authorization of Related Funding

13. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

14. Consider Appointments to the CalOptima Board of Directors' Whole-Child Family Advisory Committee

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

16. Consider Adoption of Resolution Changing the Duration of Chair and Vice Chair Terms for the CalOptima Board of Directors' Advisory Committees and Authorize Policy and Procedure Updates to Reflect These Changes

ADVISORY COMMITTEE UPDATES

17. Member Advisory Committee Update

18. OneCare Connect Member Advisory Committee Update

19. Whole Child Model Family Advisory Committee Update

20. Provider Advisory Committee Update

INFORMATION ITEMS

21. Real Estate Update

22. May and June 2020 Financial Summaries

23. Compliance Report

24. Federal and State Legislative Advocates Reports

25. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

Webinar Instructions for Joining the Regular Meeting of the CalOptima Board of Directors

August 6, 2020 at 2:00 p.m.

How to Join

1. **Please register for Regular Meeting of the CalOptima Board of Directors on August 6, 2020 2:00 PM PDT at:**
   https://attendee.gotowebinar.com/register/1498984401837590283
2. **After registering, you will receive a confirmation email containing a link to join the webinar at the specified time and date.**

   Note: This link should not be shared with others; it is unique to you.

   Before joining, be sure to check system requirements to avoid any connection issues.

3. **Choose one of the following audio options:**

   TO USE YOUR COMPUTER'S AUDIO:

   When the webinar begins, you will be connected to audio using your computer's microphone and speakers (VoIP). A headset is recommended.

   --OR—

   TO USE YOUR TELEPHONE:

   If you prefer to use your phone, you must select "Use Telephone" after joining the webinar and call in using the numbers below.

   United States: +1 (631) 992-3221

   Access Code: 811-299-555

   Audio PIN: Shown after joining the webinar

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MEMORANDUM

DATE:	July 29, 2020
TO:	CalOptima Board of Directors
FROM:	Richard Sanchez, Interim CEO
SUBJECT:	CEO Report — August 6, 2020, Board of Directors Meeting
COPY:	Sharon Dwiers, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee; and Whole-Child Model Family Advisory Committee

California Budget Enacted With Medi-Cal Rate Reduction But No Program Eliminations
On June 29, Gov. Gavin Newsom signed California's FY 2020–21 budget after the Legislature and Administration agreed on a plan to balance an estimated $54 billion deficit brought on by the COVID-19 pandemic. While the budget still contains Medi-Cal rate cuts, the elimination of optional benefits and programs for seniors was not approved. Therefore, the budget provisions are consistent with CalOptima's Board-approved FY 2020–21 operating budget. Effective July 1, the state budget impacts Medi-Cal as summarized below:

- *Benefits:* Rejects the elimination of Community-Based Adult Services (CBAS) and the Multipurpose Senior Services Program (MSSP) and preserves funding for 12 optional Medi-Cal benefits.
- *Managed Care Capitation Rates:* Approves a 1.5% rate reduction, implements a risk corridor calculation for the period July 1, 2019–December 31, 2020 (18-month bridge period) and implements efficiencies in the development of managed care plan rates.
- *Proposition 56:* Rejects the Administration's proposal to eliminate Proposition 56 supplemental payments but suspends payments on July 1, 2021, unless certain state fiscal conditions are met.
- *Managed Care Organization (MCO) Tax:* Approves the Administration's estimate of net revenue from the MCO tax of $1.7 billion.
- *Medi-Cal Expansion:* Expands full-scope Medi-Cal to undocumented older adults only if specific revenue projections for the next three years exceed the cost of providing benefits.
- *California Advancing and Innovating Medi-Cal (CalAIM):* Approves the Administration's withdrawal of funding to support CalAIM.
- *Pharmacy Carve-Out:* Approves the Department of Health Care Services (DHCS) budget request for resources to implement Medi-Cal Rx.

State Files 1115 Waiver Extension Request to Approve Programs Until 2021
On July 22, DHCS requested a 12-month extension of the federal waiver under which the majority of Medi-Cal operates. California's Section 1115 Medicaid waiver, known as Medi-Cal 2020, was approved by the Centers for Medicare & Medicaid Services (CMS) on December 30, 2015, and is effective through December 31, 2020. Following the end of the waiver period, DHCS had intended to launch CalAIM to continue important programs authorized through Medi-Cal 2020. However, COVID-19 necessitated a delay in CalAIM so the health care delivery system can focus on the pandemic. The extension request's stakeholder process includes a 30-

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day public comment period and two public hearings on August 7 and 10. CalOptima will keep your Board informed about the progress of the extension request.

New Long-Term Care at Home Medi-Cal Benefit Proposed, Driven by Pandemic
On May 22, DHCS and the California Department of Aging announced the development of a new Long-Term Care at Home benefit for Medi-Cal, aimed at reducing the nursing home population amid the pandemic by offering a coordinated and bundled set of medical and home- and community-based services. According to the proposal, services will be tailored to individual needs based on a person-centered assessment and provide choices for individuals about where to live and how to receive care. Stakeholder feedback in June resulted in modifications to the original proposal, and a updated benefit design document was released July 17 here. The document provides a more detailed overview of the proposed benefit, including its key goals, target populations, model of care, financing structure, federal authority, and public stakeholder process. DHCS will seek approval from CMS for this benefit, with a plan to launch it in 2021. To help shape the benefit, CalOptima has provided feedback through our state associations; however, we remain concerned regarding the aggressive timeframe for implementation and other operational and clinical issues.

COVID-19 Response Encompasses a Wide Range of Efforts From Clinical to Operational
CalOptima continues to respond to the intense needs of our members as we enter the sixth month since Orange County declared a local health emergency. From our first case until July 27, CalOptima has reported 2,201 positive cases, 1,138 hospitalizations and 165 deaths. Below are updates in several key areas of pandemic response.

- *Redetermination Extension:* On July 23, the federal government extended the public health emergency order another 90 days, until October 24, 2020, and DHCS announced that it will extend the freeze on Medi-Cal redeterminations accordingly. During a call about COVID-19, state officials shared that DHCS is not experiencing the enrollment spike up to 2 million new enrollees as previously expected. April enrollment data show a decrease in female applicants compared with male applicants, and children ages 0–17 make up the bulk of applications.
- *Member Communications:* CalOptima enhances the COVID-19 member section on the website on an ongoing basis. For example, we recently added the expanded list of COVID-19 symptoms released by the CDC. Member content is available in seven threshold languages.
- *Provider Communications:* The breadth of the COVID-19 provider section here reflects the challenging nature of delivering health care during the pandemic, given numerous regulatory changes and financial demands. Toward the latter, CalOptima communicated the opportunity in June for providers to obtain financial support from the $25 billion Medicaid Relief Fund: $15 billion for Medicaid providers and $10 billion for safety net hospitals. To be eligible, providers must have directly billed for recent Medi-Cal services and must not have received prior provider relief payments. The payment will be at least 2 percent of reported gross Medi-Cal revenue for a specified period.
- *Suicide Prevention:* In early July, DHCS, the California Department of Public Health and the Office of the California Surgeon General reached out with a letter for all California medical and behavioral health providers, to communicate concerns about COVID-19's immediate and long-term impact on mental health. The letter urges providers to ask four suicide screening questions developed by the National Institute on Mental Health and offers instructions and resources about what to do if someone is identified as at-risk.

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- *Nursing Home Support:* CMS recently announced funding and testing initiatives to further protect nursing home residents. Up to $5 billion of the Provider Relief Fund will be authorized for Medicare-certified long-term care facilities to boost facilities' response to COVID-19. They must participate in a training program to qualify to receive the funding. Further, CMS will begin requiring — rather than recommending — that all nursing homes in states with a 5% or higher positivity rate test all staff each week. This new staff testing requirement will enhance efforts to keep the virus from entering and spreading through nursing homes by identifying asymptomatic carriers. Meanwhile, our local efforts continue in partnership with UC Irvine and the Orange County Health Care Agency (HCA) to support infection control in nursing homes, including hosting a July 9 webinar offering resources in a new toolkit here.
- *Anaheim Testing Super Site:* On July 14, the HCA and City of Anaheim jointly announced a new drive-through testing super site at the Anaheim Convention Center. CalOptima has promoted this site on social media and in our weekly COVID-19 electronic newsletter to hundreds of community-based organizations.
- *Multilingual Ad Campaign:* CalOptima partnered with the HCA to help amplify its "Could it be COVID?" multilingual ad campaign about testing. We participated in an HCA press release here that announced the new campaign, and we posted HCA-created messages on our four social media channels. Further, CalOptima offered HCA bonus radio spots on La Ranchera 96.7 FM for additional Spanish-language announcements and included the HCA ad and message twice in our weekly COVID-19 electronic newsletter.
- *Teleworking:* CalOptima continues to consider how to protect our employees and plan for an eventual return to the office. As a first step over the next few months, CalOptima will fill nearly 70 permanent teleworking slots that are within the current Board-approved limit, thereby reducing the future census in the building. However, the executive team recognizes that significant short- and long-term modifications to our workspace will be necessary, including perhaps seeking approval for more permanent telework staff.

Whole-Child Model (WCM) Marks First Year of Successful Integration
July 1, 2020, marked the one-year anniversary of CalOptima's WCM program, which delivers better care coordination and access to care for California Children's Services (CCS) children and their families. Thanks to our effective partnership with the provider community, WCM experienced strong clinical results and positive feedback from participants. The program began with 12,317 members and grew almost 20% during the past 12 months to 14,652 members. Approximately 42% of all WCM members reside in either Santa Ana or Anaheim, and nearly all WCM members (93%) speak either English (51%) or Spanish (42%). There is some work to do to address CCS eligibility discrepancies and funding issues, and our finance team is focused on correcting the gaps with support from state associations. Thanks for your Board's support during the launch and first year of operation.

CalOptima Engages Orange County Congressional Delegation in Virtual Meetings
In June, the Association for Community Affiliated Plans conducted its annual legislative advocacy efforts virtually this year, and CalOptima connected over the phone with five Congressional offices. I spoke with Reps. Lou Correa, Alan Lowenthal, Harley Rouda and Gil Cisneros as well as a staffer from the office of Rep. Katie Porter. The discussions ranged from the pandemic's impact on provider funding and Medi-Cal policies to the availability of COVID-19 testing and mental health resources in our community. More recently, I was able to meet

virtually with the remaining members of our Congressional delegation, Reps. Linda Sanchez and Mike Levin, and the conversations covered similar issues.

Health Homes Program (HHP) Phase 2 Focuses on Needs of Members With Mental Illness
On July 1, CalOptima launched Phase 2 of HHP, which provides a new set of care management and coordination services to Medi-Cal members with serious mental illnesses. The goal of HHP Phase 2 continues to be the same as Phase 1, which is to promote access to the full range of physical, behavioral and social services for members with complex needs, and to empower them to play an active role in their health. Nearly 4,700 members are eligible to participate in Phase 2, and we estimate that 20% will enroll. Through July, 480 members enrolled in HHP during Phase 1, which includes members with certain chronic conditions and substance use disorders.

Medi-Cal Rx All-Plan Webinar Begins the Preparation for January 2021 Transition
In June, DHCS held an all-plan webinar about the upcoming transition to Medi-Cal Rx on January 1, 2021. The state reiterated its commitment to that start date and shared that system testing with pharmacy vendor Magellan Healthcare has begun. To gather input from health plans and associations, the state will soon release a draft All-Plan Letter that outlines managed care plan requirements after Medi-Cal Rx implementation and addresses a variety of issues at the plan level, such as policies and procedures, pharmacy provider networks, formularies, utilization management, and grievances and appeals. Regarding member communication, DHCS will provide managed care plans with call scripts that give members information about how to contact Magellan. Also, 90-, 60- and 30-day notices will be sent to members. While CalOptima has many reservations about this transition, we are particularly concerned about its impact on CCS members. Working through the CCS Advisory Group, we have asked the state to make several changes to the formulary specific to that population.

DHCS Medi-Cal Audit Wraps Up With Draft Findings in Access to Care, Grievances
The DHCS on-site audit of CalOptima's Medi-Cal program as well as Medicaid-based services for OneCare Connect took place from January 27–February 7, 2020. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare. On July 1, DHCS issued a draft report with preliminary findings in the areas of access and availability of care and the grievance system, and on July 7, DHCS and CalOptima met for an exit conference. After receipt of the final report, CalOptima will respond with a Corrective Action Plan. We will keep your Board informed about remediation efforts.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 4, 2020

A Regular Meeting of the CalOptima Board of Directors was held on June 4, 2020 at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act. Chair Paul Yost, M.D. called the meeting to order at 2:00 p.m. Sharon Dwiers led the Pledge of Allegiance.

ROLL CALL

Members Present: Dr. Nikan Khatibi, Vice Chair (at 2:04 p.m.); Ria Berger (at 2:04 p.m.); Clayton Chau, M.D. (non-voting); Ron DiLuigi; Alexander Nguyen, M.D.; Lee Penrose; Scott Schoeffel; Supervisor Michelle Steel (at 2:26 p.m.); Paul Yost, M.D., Chair (All members at teleconference locations except the Chair)

Members Absent: Supervisor Andrew Do

Others Present: Richard Sanchez, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Ladan Khamseh, Chief Operating Officer; Sharon Dwiers, Clerk of the Board

Chair Yost noted that protest activities were planned at the Outlets of Orange adjacent to CalOptima's offices at 5:00 p.m. and indicated that where possible, he would be suggesting that related agenda items be combined in order to expediate review and approval.

PRESENTATIONS

Interim Chief Executive Officer (CEO) Richard Sanchez recognized the following outgoing Board Members: Chair Paul Yost, M.D., Vice Chair Dr. Nikan Khatibi, Director Ria Berger, Director Ron DiLuigi, Director Alexander Nguyen, M.D., and Director Lee Penrose for their service and commitment to CalOptima and the members it serves.

PUBLIC COMMENTS

1. Patty Mouton, Chair, OneCare Connect Member Advisory Committee (OCC MAC) – Oral re: Funding for Adult Day Health Care (ADHC)/Community-Based Adult Services (CBAS)
2. Gio Corzo, on behalf of Meals on Wheels, Orange County – Oral re: Funding for ADHC/ CBAS
3. Mallory Vega, Alzheimer's Orange County, Acacia Adult Day Services, South County Adult Day Services, and a Member of the Member Advisory Committee – Oral re: Funding for ADHC/CBAS
4. Kerri Ruppert Schiller, CHOC – Oral re: Agenda Item 8, Consider Approval of the CalOptima Fiscal Year 2020-21 Operating Budget and recent rebasing results.

MANAGEMENT REPORTS

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1. Chief Executive Officer Report

Mr. Sanchez noted that the Legislature is currently reviewing the Governor's proposed FY2020-21 State budget, and that staff will continue to provide updates to the Board on any changes and their impact to CalOptima.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the May 7, 2020 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the February 19, 2020 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; the February 20, 2020 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; the December 19, 2019 Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee; the February 25, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee; the March 12, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the April 9, 2020 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee and Provider Advisory Committee

3. Consider Ratification of Expenditures Related to Emergency Repairs for CalOptima Facilities

4. Consider Approval of Proposed Changes to CalOptima Policy GA.3400: Annual Investments

5. Consider Approval of Proposed Revisions to CalOptima Finance Policies

6. Consider Approval of CalOptima Medi-Cal Directed Payments Policy and Modifications to Claims Administrations Policies and Procedures

7. Consider Approval of the 2019 CalOptima Utilization Management (UM) Program Evaluation and the 2020 CalOptima UM Program

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

REPORTS

8. Consider Approval of the CalOptima Fiscal Year 2020-21 Operating Budget

Finance and Audit Committee (FAC) Chair Lee Penrose briefly introduced this item, noting that he was happy with the changes staff had made based on input from the FAC Members.

Nancy Huang, Chief Financial Officer, provided an overview of the FY2020-21 Operating Budget, including a review of Governor Newsom's May Revise, which included significant rate cuts for the Medi-Cal program, as well as other benefit reductions and program eliminations.

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Ms. Huang noted that CalOptima's overall revenue reductions are deeper than anticipated and provided a detailed overview of the proposed FY2020-21 Operating Budget. Staff recommends moving forward with planned provider cuts based on rebasing, but also recommends that CalOptima absorb the state rate cuts by making up the difference using reserves. In addition, Ms. Huang reviewed the results of the health network rebasing exercise conducted by CalOptima's consultant, Milliman Inc., noting that staff is committed to working with its healthcare partners and will be validating the rebasing results and will bring changes back to the Board if needed.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors 1.) Approved the CalOptima Fiscal Year (FY) 2020-21 Operating Budget; and 2.) Authorized the expenditures and appropriated the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 8-0-0; Supervisor Do absent)***

9. Consider Approval of the CalOptima Fiscal Year 2020-21 Capital Budget

Ms. Huang briefly introduced the proposed CalOptima Fiscal Year 2020-21 Capital Budget.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1) Approved the CalOptima Fiscal Year (FY) 2020-21 Capital Budget; and 2.) Authorized the expenditures and appropriated the funds for the items listed in Attachment A: Fiscal Year 2020-21 Capital Budget by Project, which shall be procured in accordance with CalOptima's Board-approved policies. (Motion carried 8-0-0; Supervisor Do absent)***

10. Consider Approval of Remedial Actions Related to Health Network and Provider Overpayments Arising from Medi-Cal Member Eligibility Reporting Error

Director DiLuigi did not participate in this item due to his affiliation with St. Jude Clinic. Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor Steel did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO) to waive the recovery of additional overpayments made to Health Networks and Providers for the period of August 1, 2014 through August 30, 2018 based on a System Coding Logic Error and made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose. (Motion carried 5-0-0; Supervisor Do absent; Directors DiLuigi, Schoeffel and Supervisor Steel recused)***

11. Consider Actions Related to Intergovernmental Transfer (IGT) 5, 6 and 7 Community Grant Contracts in Response to COVID-19

Director Berger did not participate in this item due to her affiliation with Health Smiles for Kids of Orange County. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend contract agreements with IGT 5, 6 and 7 community grantees to allow for the following when applicable: a.) No-Cost time extension to the grants for the purpose of completing workplan deliverables; b.) Temporary modifications to the Scope of Work to include a modified delivery of service when the request does not impact the objective or number of members served; and/or c.) Revisions to the budget line item due to statutory changes; changes in direct response to COVID-19 new guidelines, or to address the temporary modification in Scope of Work. (Motion carried 6-0-0; Supervisor Do absent; Directors Berger and Schoeffel recused)***

Chair Yost noted that unless there were questions from fellow Board Members, in the interest of time, he would like to consider Agenda Items 12, 13, and 14 with a single motion, The items involve regulator contracts: one with the California Department of Aging (CDA) for the MSSP program, and two contract amendments with the California Department of Health Care Services (DHCS), one for the PACE program, and one for the OneCare and OneCare Connect programs. Hearing no questions, Agenda Items 12 through 14 were considered in a single motion.

12. Consider Adopting Resolution Authorizing and Directing Execution of Contract with the California Department of Aging for the Multipurpose Senior Services Program

Recommended actions for Agenda Items 12 through 14 were each read into the record and approved in one motion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Adopted Board Resolution No. 20-0604-01, authorizing and directing the Chairman of the Board to execute Contract MS-20-21-41 with the California Department of Aging for the Multipurpose Senior Services Program for Fiscal Year 2020-21 (Motion carried 8-0-0; Supervisor Do absent)***

13. Consider Authorizing and Directing Execution of Amendment to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized and directed the Chairman of the Board of Directors to execute Amendment A10 to the Program of All-Inclusive Care for the Elderly (PACE) Agreement between the California Department of Health Care Services (DHCS) and CalOptima regarding extension of the contract termination date to December 31, 2020 and adding the Calendar Year (CY) 2020 capitation rates. (Motion carried 8-0-0; Supervisor Do absent)***

14. Consider Authorizing Execution of Amendment to Agreement with the California Department of Health Care Services in Order to Continue Operation of the OneCare and OneCare Connect Programs

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Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors Authorized and directed the Chairman of the Board of Directors to execute an Amendment to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS) in order to continue operating of the OneCare and OneCare Connect programs. (Motion carried 8-0-0; Supervisor Do absent)***

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Chair Yost did not participate in this item due to his affiliation with CHOC as a physician anesthesiologist. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to: 1.) Extend the term through June 30, 2021; 2.) Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and 3.) Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget. (Motion carried 6-0-0; Supervisor Do absent; Chair Yost and Director Schoeffel recused)***

Chair Yost noted that unless there were questions from fellow Board Members, in the interest of time, he would like the Board to consider Agenda Items 16, 17, 18, and 19, which involve policy updates, in a single motion. Hearing no questions, Agenda Items 16 through 19 were all considered in a single motion.

16. Consider Authorizing Modifications to Quality Improvement Policies

Recommended actions for Agenda Items 16 through 19 were each read into the record and approved in one motion and vote.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Approved modifications to the following CalOptima policies pursuant to CalOptima's annual review process: a.) GG.1651: Organizations Assessment and Reassessment of Organizational Providers; and b.) GG.1657: Medical Board of California and the National Practitioner Data Bank (NPDB) Reporting (Motion carried 8-0-0; Supervisor Do absent)***

17. Consider Approval of Revisions to Finance Policies and Procedures

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized revisions to the following CalOptima policies: 1.) FF.1001: Capitation Payments; and 2.) CMC.3001: Payment Arrangements to Health***

Networks – Capitation Payments. (Motion carried 8-0-0; Supervisor Do absent)

18. Consider Approving Updates to Policy EE.1103: Provider Education and Training

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors Approved updates to Policy EE.1103 Provider Education and Training, for CalOptima Medi-Cal, OneCare, OneCare Connect, and PACE. (Motion carried 8-0-0; Supervisor Do absent)***

19. Approve Revised CalOptima Policies AA.1204: Gifts, Honoraria, and Travel Payments and AA.1216: Solicitation and Receipt of Gifts to CalOptima

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors approved revised CalOptima Policies: 1.) AA.1204: Gifts, Honoraria, and Travel Payments; and 2.) AA.1216: Solicitation and Receipt of Gifts to CalOptima. (Motion carried 8-0-0; Supervisor Do absent)***

20. Consider Approval of Reimbursement for Necessary Business Expenditures Incurred by Regular Full Time or Part-Time Employees on Temporary Telework in Response to the Public Health Emergency Arising from the Coronavirus (COVID-19) Pandemic

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors 1.) Approved reimbursement at a flat rate of $45 per month, commencing April 1, 2020 through June 30, 2020 for necessary business expenditures incurred by regular full-time and part-time employees on temporary telework in response to the public health emergency arising from the COVID-19 pandemic; 2.) Authorized the Chief Executive Officer (CEO) to extend the flat reimbursement rate month-to-month thereafter through December 31, 2020 for employees required to remain on temporary telework; 3.) Authorized unbudgeted expenditures of up to $114,750 from existing reserves to fund the reimbursement for necessary business expenses of employees on temporary telework for the period of April 1, 2020, through June 30, 2020; and 4.) In the event the CEO authorizes the extension of the flat reimbursement rate on a month-to-month basis for all or part of the period of July 1, 2020, through December 31, 2020, authorize unbudgeted expenditures of up to $229,500 from existing reserves to fund the reimbursement of business expenses for employees on temporary telework. (Motion carried 8-0-0; Supervisor Do absent)***

21. Consider Authorizing Extension of State Legislative Advocacy Services Contract

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 exercise the option to extend the contract of Edelstein Gilbert Robson &***

Smith for state legislative advocacy services for one year, per the terms of the current contract, commencing July 1, 2020. (Motion carried 8-0-0; Supervisor Do absent)

22. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Primary Care Physician, Specialty Physician, and Clinic Fee-for-Service Contracts, Except Those Involving Providers Affiliated with St. Joseph Health

Chair Yost did not participate in this item due to his affiliation with CHOC as a physician anesthesiologist. Director Schoeffel did not participate in this item due to potential conflicts of interest. Supervisor Steel did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Direct Medi-Cal Primary Care Physician, Specialist Physician, and Clinic Fee-for-Service (FFS) Contracts Except Those Involving Providers Affiliated with St. Joseph Health, to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012. (Motion carried 5-0-0; Supervisor Do absent; Chair Yost, Director Schoeffel and Supervisor Steel recused)***

23. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health

Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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 amend the CalOptima Direct Medi-Cal Non-Clinic Primary Care Physician Fee-for-Service (FFS) Contracts for Providers Affiliated with St. Joseph Health, to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012. (Motion carried 6-0-0; Supervisor Do absent; Directors Penrose and Schoeffel recused)***

24. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Clinic Fee-for-Service Contracts with Clinics Affiliated with St. Joseph Health

Director DiLuigi did not participate in this item due to his affiliation with St. Jude Clinic. Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Direct Medi-Cal Clinic Fee-for-Service (FFS) Contracts with Clinics affiliated with St. Joseph Health, to add language allowing applicable Directed Payments to be made per CalOptima Policy and***

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Procedure FF.2012. (Motion carried 5-0-0; Supervisor Do absent; Directors DiLuigi, Penrose and Schoeffel recused)

25. Consider Authorizing Amendments to the CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service Contracts for Providers Affiliated with St. Joseph Health

Chair Yost did not participate in this item due to his affiliation with Providence St. Joseph Health as a physician anesthesiologist. Director Penrose did not participate in this item based on his affiliation with Providence St. Joseph Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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 amend the CalOptima Direct Medi-Cal Specialist Physician Fee-for-Service (FFS) Contracts for Providers Affiliated with St. Joseph Health to add language allowing applicable Directed Payments to be made per CalOptima Policy and Procedure FF.2012. (Motion carried 5-0-0; Supervisor Do absent; Chair Yost and Directors Penrose and Schoeffel recused)***

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors adopted Resolution approving updates to the following CalOptima Human Resources Policies: 1.) GA.8055: Retiree Health Benefits; 2.) GA.8025: Equal Employment Opportunity; 3.) AA.1250: Disability Awareness and Sensitivity, and Cultural Competency Staff Training; 4.) CMC.1003: CalOptima OneCare Connect Staff Education and Training; and 5.) GA.8057: Compensation Program. (Motion carried 8-0-0; Supervisor Do absent)***

27. Consider Authorization of a Grant Agreement with the County of Orange for Medical Respite Care

Director Chau did not participate in this item due to his position with Orange County Health Care Agency. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Vice Chair Khatibi, seconded and carried, the Board of Directors 1.) Authorized the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to: a.) Enter into a Grant Agreement with the County of Orange to fund the County's Post Whole Person Care Medical Respite Program in the amount of $250,000, effective June 1, 2020; and b.) Amended the Coordination and Provision of Public Health Care Services Contract with the County of Orange to reflect the termination of CalOptima's Medical Respite program effective June 1, 2020. (Motion carried 7-0-0; Supervisor Do absent; Directors Chau and Schoeffel recused)***

28. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors for Fiscal Year 2020-21

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Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors 1.) Authorized expenditures of $9,800 for board membership in the National Association of Corporate Directors (NACD) for Fiscal Year (FY) 2020-21; and 2.) Authorized up to $20,300 for additional seminars and related travel expenses. (Motion carried 7-1-0; Supervisor Do absent; Supervisor Steel voting no)***

29. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2020-21

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors adopted the proposed meeting schedule of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period July 1, 2020 through June 30, 2021. (Motion carried 8-0-0; Supervisor Do absent)***

Chair Yost noted that unless there were questions, and in the interest of time, he would like the Board to consider Agenda Items 30 and 31, which involve advisory committee appointments and reappointments, in a single motion. Hearing no questions, Agenda Items 30 and 31 were considered in a single motion.

30. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee
Recommended actions for Agenda Items 30 and 31 were each read into the record and approved in one motion and vote.

Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1.) Reappointed the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2020; a.) Pamela Pimentel as the Children Representative for a term ending June 30, 2022; b.) Sr. Mary Therese Sweeney as the Behavioral/Mental Health Representative for a term ending June 30, 2022; c.) Sally Molnar as the Medical Safety Net Representative for term ending June 30, 2022; d.) Christine Tolbert as the Persons with Special Needs Representative for a term ending June 30, 2022; and 2.) Appointed the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2020: a.) Melisa Nicholson as the Foster Children Representative for a term ending June 30, 2022; b.) Patty Mouton as the Long-Term Services and Supports Representative for a term ending June 30, 2022; and 3.) Appointed the following individual to fulfill a remaining term effective upon Board appointment: a.) Maura Byron as the Family Support Representative for a term ending June 30, 2021. (Motion carried 8-0-0; Supervisor Do absent)***

31. Consider Provider Advisory Committee Recommended Appointments to the CalOptima Board of Directors' Provider Advisory Committee

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Action: ***On motion of Director Penrose, seconded and carried, the Board of Directors 1.) Appointed Christy Ward as the Community Health Centers Representative, for a three-year term ending June 30, 2023; 2.) Appointed Jena Jensen as the Hospitals Representative, for a three-year term ending June 30, 2023; 3.) Appointed Alpesh Amin, MD, MBA, MACP, SFHM, FACC, FRCP (Lond) as the Physician Representative, for a three-year term ending June 30, 2023; 4.) Appointed Alexander Rossel as the Safety Net Representative, for a three-year term ending June 30, 2023; 5.) Appointed Jennifer Birdsall as an Allied Health Representative, to fulfill a remaining term through June 30, 2022; and 6.) Appointed Peter Korchin as an Allied Health Representative, to fulfill a remaining term through June 30, 2021. (Motion carried 8-0-0; Supervisor Do absent)***

Chair Yost reiterated that protests were planned near CalOptima's offices. On his recommendation, and to ensure the safety of staff and other attendees, the Board accepted the following items as presented.

ADVISORY COMMITTEE UPDATES

32. OneCare Connect Member Advisory Committee Update

33. Whole Child Model Family Advisory Committee Update

34. Provider Advisory Committee Update

35. Member Advisory Committee Update

INFORMATION ITEMS

36. Impact of COVID-19 on Quality and Vulnerable Population

37. CalOptima Members Experiencing Homelessness Update

38. April 2020 Financial Summary

39. Compliance Report

40. Federal and State Legislative Advocates Reports

41. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Outgoing Board Members were again thanked for their service.

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ADJOURNMENT
Hearing no further business, the meeting was adjourned at 3:53 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: August 6, 2020

Back to Agenda

MINUTES

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

April 23, 2020

A Regular Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) was held via Webinar on April 23, 2020 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Patty Mouton called the meeting to order at 3:05 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Chair; Gio Corzo, Vice Chair' Josefina Diaz; Sandra Finestone; Keiko Gamez; Sara Lee; Mario Parada; Donald Stukes; Jyothi Atluri (non-voting)

Members Absent: Erin Ulibarri (non-voting)

Others Present: Richard Sanchez, Interim Chief Executive Officer; Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Belinda Abeyta, Executive Director, Operations; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Management; Tracy Hitzeman, Executive Director, Clinical Operations; Miles Masatsugu, M.D., Medical Director; Albert Cardenas, Director, Customer Service; Carlos Soto, Manager, Cultural and Linguistics; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant, Customer Service.

MINUTES

Approve the Minutes of the February 27, 2020 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC)

Action: ***On motion of Member Josefina Diaz, seconded and carried, the Committee approved the minutes of the February 27, 2020 meeting by a roll call vote. (Motion carried 8-0-0)***

PUBLIC COMMENT

There were no requests for public comment.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer, introduced himself to the Committee and thanked Michael Schrader for his guidance through the transition.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, welcomed Richard Sanchez and provided a verbal update on the Qualified Medicare Beneficiary (QMB) Program outreach to the members. Ms. Khamseh noted that CalOptima has had a good success rate in reaching qualified Part A members.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, provided a verbal update on CalOptima's collaboration with the Orange County Health Care Agency and other stakeholders regarding the Coronavirus (COVID-19). He noted that the Health Homes Program phase two is still on schedule for roll-out July 1, 2020. Dr. Ramirez also discussed the CalAIM Pharmacy carve out and the Department of Health Care Services (DHCS) Behavioral Health initiatives.

INFORMATION ITEMS

OCC MAC Member Updates

Chair Mouton reminded the members that recruitment was extended until April 30, 2020. She noted that the following seats have terms expiring on June 30, 2020, Community Based Adult Services (CBAS) Provider, Long Term Services and Supports, Member Advocate, Member or Family Member and Seniors Representatives and noted that those members who do not reapply will not be considered for reappointment. Chair Mouton formed a nominations ad hoc committee to review and score the applications that are received for the vacant seats. The nominations ad hoc committee will consist of Mario Parada, Sara Lee, and Josefina Diaz.

Coronavirus (COVID-19) Presentation

Mile Masatsugu, M.D., Pace Medical Director, provided a comprehensive presentation on COVID-19. He discussed CalOptima's and Orange County's testing capabilities and noted that CalOptima's COVID-19 response was in educating members and ensuring their access to care, and CalOptima's status of temporary telework staff.

Trauma Informed Care and Proposition 56 (Tobacco Tax) ACE Screening Presentation

Betsy Ha, Executive Director, Quality and Population Health Management, presented on Trauma-Informed Care and Adverse Childhood Experiences (ACE) Screening. Ms. Ha discussed the impact of trauma on heath, evidence-based studies of ACE's and the impact to population health and trauma informed care. Ms. Ha also provided a handout from the California Surgeon General's Playbook regarding Stress Relief during COVID-19.

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Federal and State Legislative Update

TC Roady, Director, Regulatory Affairs and Compliance, provided a verbal update on the State and Federal Government's COVID-19 response including the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) guidance.

Cultural and Linguistics Update

Carlos Soto, Manager, Cultural and Linguistics, provided a brief overview of the cultural and linguistic services available for the CalOptima members. Mr. Soto's discussion included member utilization data using telephonic, face to face interpreter & translation services and how Cultural & Linguistics utilizes both internal staff and contracted vendors to ensure members are provided with timely translation and interpretation services.

ADJOURNMENT

Chair Mouton announced that the next regular meeting would be held on Thursday, June 25, 2020 at 3:00 p.m.

There being no further business, the meeting adjourned at 5:10 p.m.

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

Approved: June 25, 2020

Back to Agenda

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Member Advisory Committee
FY 2019-20 Accomplishments

During FY 2019-20 the OneCare Connect Member Advisory Committee (OCC MAC) of the CalOptima Board of Directors provided input to ensure that OneCare Connect members receive quality health care services. The following list highlights the accomplishments:

- OCC MAC members outreached to Orange County organizations and agencies to invite community stakeholders to present on member needs and concerns at OCC MAC meetings. Presentations included palliative care, end-of-life considerations, homelessness, mental illness, opioid/substance abuse and COVID-19.

- OCC MAC member, whose agency serves as Orange County's Cal MediConnect Ombudsman Program, provided updates and feedback from dual-eligible members and the community regarding the OneCare Connect program.

- An OCC MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates. The OCC MAC reviewed the proposed candidates at its June 25, 2020 meeting and forwarded their recommendations to the Board for consideration and approval at their August 6, 2020 meeting.

- OCC MAC members provided input on CalOptima's strategies to maximize enrollment, retention, and member outreach efforts to OneCare Connect members.

- OCC MAC members attended CalOptima sponsored community education events, including Community Alliance Forums and Awareness and Education Seminars.

- All OCC MAC members completed the annual Compliance Training.

- OCC MAC Chair or Vice Chair presented bi-monthly OCC MAC Reports at CalOptima Board of Directors' meetings to provide the Board with input and updates on the OCC MAC's activities.

- OCC MAC members contributed over 170 hours to CalOptima during FY 2019-20, including OCC MAC meetings, ad hoc meetings, and Board meetings. These hours do not account for the innumerable hours that OCC MAC members dedicate to members on a day-to-day basis which is equal to 21 business days.

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The OCC MAC thanks the CalOptima Board for the opportunity to provide updates on the OCC MAC's activities. The OCC MAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

Approved: June 25, 2020

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MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' WHOLE CHILD MODEL FAMILY ADVISORY COMMITTEE

April 28, 2020

A Regular Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee (WCM FAC) was held on April 28, 2020, via Goto Meeting Webinar at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Maura Byron called the meeting to order at 9:40 a.m.

ESTABLISH QUORUM

Members Present: Maura Byron, Chair; Cathleen Collins; Brenda Deeley; Jacqui Knudsen; Kathleen Lear; Monica Maier; Kristen Rogers; Malissa Watson

Members Absent: Sandra Cortez-Schultz

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operations Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Miles Masatsugu, M.D., Pace Medical Director; TC Roady, Director, Regulatory Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Belinda Abeyta, Executive Director, Operations; Albert Cardenas, Director, Customer Service: Carlos Soto, Manager, Cultural and Linguistic, Customer Service; Cheryl Simmons, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Assistant, Customer Service

MINUTES

Approve the Minutes of the December 10, 2019 Special Meeting of the CalOptima Board of Directors' Whole-Child Model Family Advisory Committee

Action: ***On motion of Member Rogers, seconded and carried, the WCM FAC Committee approved the minutes of the December 10, 2019 meeting. (Motion carried 8-0-0; Member Cortez-Schultz absent)***

PUBLIC COMMENT

There were no public comments received.

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer, introduced himself to the Committee and discussed his background with the Orange County Health Care Agency (OCHCA) and his familiarity with the Whole-Child Model program and with California Children Services (CCS).

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, expressed her gratitude to the leadership provided by Michael Schrader the past seven years and welcomed Richard Sanchez to CalOptima. Ms. Khamseh deferred her report to allow more time for the presentations.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, noted during his update that CalOptima is continuing to focus on key performance indicators and authorization requests for elected procedures. Dr. Ramirez also mentioned that the Whole-Child Model is approaching it's one year anniversary with CalOptima. Dr. Ramirez asked Tracey Hitzeman, Executive Director of Clinical Operations to provide an update on the continuity of care period which is nearing its conclusion.

INFORMATION ITEMS

Whole-Child Model Member Updates

Chair Byron reminded the members whose seats were expiring on June 30, 2020 that they would need to reapply before the deadline of April 30, 2020. She also noted that the Committee still has two Authorized Family Member Representative openings and asked the members to help recruit for these open seats. Chair Byron also formed an ad hoc committee to review and score the applications received from the recruitment of which Member Deeley agreed to serve on. Chair Byron asked the remaining eligible members to contact Cheryl Simmons with their interest in serving on the ad hoc. Chair Byron also noted that the committee would be approving the new meeting schedule for 2020-21 at their June 23, 2020 meeting.

CHOC Children's Thompson Autism Center Presentation

Jonathan T. Megerian, M.D., a Board-Certified Pediatric Neurologist at Children's Hospital of Orange County (CHOC) provided a comprehensive presentation on CHOC's new Thompson Autism Center. Dr. Megerian described the benefits and services that are being offered at the state-of-the art center which opened in January 2020. Dr. Megerian also provided an overview of the assessment clinic, the challenging behavior unit, and the co-occurring clinic which is available to children and their families, which elicited questions and discussion from the committee members.

Coronavirus (COVID-19) Update

David Ramirez, M.D., Chief Medical Officer and Miles Masatsugu, M.D., Program of All-Inclusive Care for the Elderly (PACE) Medical Director, provided an informative presentation on COVID-19. Dr. Ramirez discussed Orange County's current testing capabilities, CalOptima's COVID-19 response in educating members and ensuring their timely access to care.

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Federal and State Legislative Update
TC Roady, Director, Regulatory Affairs, provided a verbal update on the State and Federal Government's COVID-19 response including Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid Services (CMS) guidance.

Cultural and Linguistics Update
Carlos Soto, Manager, Cultural and Linguistics, provided a brief overview of the cultural and linguistic services offered to CalOptima members. Mr. Soto's discussion included member utilization data of telephonic, face to face interpreter and translation services and how Cultural & Linguistics utilizes both internal staff and contracted vendors to ensure members are provided with timely translation and interpretation services.

ADJOURNMENT
Chair Byron announced that the next regular meeting would be held on Tuesday, June 23, 2020 at 9:30 a.m.

Hearing no further business, Chair Byron adjourned the meeting at 11:44 a.m.

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

Approved: June 23, 2020

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MINUTES

SPECIAL MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE

May 14, 2020

A Special Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on May 14, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

Chair Tolbert called the meeting to order at 2:35 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Christine Tolbert, Chair; Pamela Pimentel, Vice Chair; Diana Cruz-Toro; Hai Hoang; Mallory Vega; Patty Mouton; Sally Molnar; Sandy Finestone; Sr. Mary Therese Sweeney.

Members Absent: Connie Gonzalez, Jamie Munoz

Others Present: Richard Sanchez, Interim Chief Executive Officer, Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Gary Crockett, Chief Counsel; Emily Fonda, M.D., Deputy Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Belinda Abeyta, Executive Director, Operations; Tracy Hitzeman, Executive Director Clinical Operations; Betsy Ha, Executive Director, Quality & Population Health Management; TC Roady, Director, Regulatory Affairs; Albert Cardenas, Director, Customer Service; Cheryl Simmons, Sr. Program Specialist, Staff to the Advisory Committees, Customer Service; Samantha Fontenot, Program Assistant, Customer Service.

MINUTES

Approve the Minutes of the February 25, 2020 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Sandra Finestone, seconded and carried, the MAC approved the minutes as submitted. (Motion carried 9-0-0, Members Gonzalez and Munoz absent)***

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Approve the Minutes of the April 9, 2020 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee, and Provider Advisory Committee

Action: ***On motion of Member Sally Molnar, seconded and carried, the MAC approved the minutes as submitted. (Motion carried 9-0-0, Members Gonzalez and Munoz absent)***

PUBLIC COMMENT
No public comment.

REPORTS

Consider Approval of the MAC FY 2020-2021 Meeting Schedule
MAC members reviewed the proposed FY 2020-2021 meeting schedule. It was noted that the MAC would continue to meet on a bi-monthly basis on the second Thursday of every other month.

Action: ***On motion of Member Pamela Pimentel, seconded and carried, the Committee approved the FY 2020-202 Meeting Schedule. (Motion carried 9-0-0, Members Gonzalez and Munoz absent)***

Consider Recommendation of Member Advisory Committee Slate of Candidates
Member Mallory Vega on behalf of the MAC Nominations Ad Hoc Committee, which also consisted of members Connie Gonzalez and Diana Cruz-Toro presented the MAC slate of candidates. She noted that the ad hoc committee had met on May 8, 2020 to review 15 applications and make recommendations on seven seats whose term expires on June 30, 2020. The ad hoc reviewed applicants for: Children, Consumer, Foster Children, Long-Terms Services and Supports, Medical Safety Net, Behavioral/Mental Health, and Persons with Special Needs Representatives and one application for the Family Support Representative seat to fulfill a remaining term through June 30, 2021. There were no applicants for the Consumer Representative.

Consider Recommendation for Persons with Special Needs Representative
Two applications were reviewed for the Persons with Special Needs Representative and the ad hoc committee recommended the reappointment of Christine Tolbert.

Action: ***On motion of Member Pamela Pimentel, seconded and carried, the Committee approved the recommendation to reappoint Christine Tolbert as the Persons with Special Needs Representative. (Motion carried 8-0-1, Members Gonzalez and Munoz absent; Member Tolbert abstained)***

Member Vega then turned the remaining recommendations over to Chair Tolbert to review and announce the recommendations for the remaining slate of candidates.

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Consider Recommendation for Children Representative

One application was reviewed and the ad hoc committee recommended the reappointment of Pamela Pimentel for the Children Representative.

Action: ***On motion of Member Sr. Mary Therese Sweeney, seconded and carried, the Committee approved the Recommendation of the Children Seat. (Motion carried 8-0-1, Members Gonzalez and Munoz absent, Member Pimentel abstained)***

Consider Recommendation for Foster Children Representative

Three applications were reviewed for the Foster Children Representative. The ad hoc recommended the new appointment of Melisa Nicholson.

Action: ***On motion of Member Pamela Pimentel, seconded and carried, the Committee approved the recommendation of Melisa Nicholson as the Foster Children Representative. (Motion carried 9-0-0, Members Gonzalez and Munoz absent)***

Consider Recommendation for Long-Term Services and Supports Representative

One application was reviewed for the Long-Term Services and Supports Representative and the ad hoc recommended the new appointment of Patty Mouton.

Action: ***On motion of Member Sandra Finestone, seconded and carried, the Committee approved the Recommendation to appoint Patty Mouton as Long-Term Services and Supports Representative. (Motion carried 8-0-1, Members Gonzalez and Munoz absent; Member Mouton abstained)***

Consider Recommendation for Medical Safety Net Representative

Four applications were reviewed for the Medical Safety Net Representative and the ad hoc committee recommended the reappointment of Sally Molnar.

Action: ***On motion of Member Sandra Finestone, seconded and carried, the Committee approved the recommendation of to reappoint Sally Molnar as the Medically Safety Net Representative. (Motion carried 9-0-0, Members Gonzalez and Munoz absent)***

Consider Recommendation for Behavioral/Mental Health Representative

Two applications were reviewed for the Behavioral/Mental Health Representative and the ad hoc recommended the reappointment of Sister Mary Therese Sweeney.

Action: ***On motion of Member Sandra Finestone, seconded and carried, the Committee approved the recommendation to reappoint Sister Mary Therese Sweeney as the Behavioral Health/Mental Health Representative. (Motion carried 8-0-1, Members Gonzalez and Munoz absent; Member Sweeney abstained)***

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Consider Recommendation for Family Support Representative
One application was reviewed for the Family Support Representative and the ad hoc recommended the appointment of Maura Byron as the Family Support Representative to fulfill a remaining term through June 30, 2021.

Action: ***On motion of Member Sally Molnar, seconded and carried, the Committee approved the recommendation of Maura Byron as the Family Support Representative. (Motion carried 9-0-0, Members Gonzalez and Munoz absent)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer (CEO) Update
Richard Sanchez, Interim Chief Executive Officer (CEO), provided an update on the CalOptima sub-committee that will be voting to appoint new CalOptima Board of Director's for the open Board seats, the final vote will be held at the June 4, 2020 Board of Director's meeting. Mr. Sanchez also discussed COVID-19 testing availability within Orange County and the continued partnership with the Orange County Healthcare Agency (OCHCA) and other stakeholders and noted that Governor Newsom's May Revise for the California State budget had just been released.

Chief Operating Officer (COO) Update
Ladan Khamseh, Chief Operating Officer (COO), provided a verbal update noting that CalOptima is providing frequent fax blasts and email alerts to providers and health networks with informative updates regarding COVID-19. Ms. Khamseh noted that CalOptima's Customer Service Department is also outreaching to members to notify them of telehealth services, mental health services, and home delivery for their prescriptions. Ms. Khamseh also updated the members on the status of the Qualified Medicare Beneficiary (QMB) project that has been on-going with outreach to members who qualify for Medicare Part A.

INFORMATION ITEMS

MAC Member Updates
Chair Tolbert thanked Ilia Rolon for her service as the MAC Family Support Representative. Ms. Rolon resigned her Family Support seat in March. Mrs. Tolbert also reminded the Committee to submit their MAC Accomplishments to Cheryl Simmons before June 1, 2020. She also noted that the Advisory Committees would be scheduling a virtual joint ad hoc meeting to review the individual committees' Goals and Objectives sometime in mid-June or July.

Coronavirus (COVID-19) Update
Emily Fonda, M.D., Deputy Chief Medical Officer, presented on the COVID-19 pandemic. Dr. Fonda updated the committee on CalOptima's COVID-19 response and noted that CalOptima continues to monitor and follow county and state public health guidance.

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Virtual Care Strategy and Road Map Presentation

Betsy Ha, Executive Director, Quality and Population Health Management introduced Sajid Ahmed, CalOptima's Virtual Care consultant and CEO of WISE Healthcare. Mr. Ahmed gave a comprehensive presentation on CalOptima's Virtual Care Strategy Plan providing examples of virtual care modalities such as virtual visits and e-visits. Ms. Ha discussed CalOptima's Virtual Care Roadmap and guiding principles during COVID-19 and post COVID-19.

Federal and State Legislative Update

TC Roady, Director, Regulatory Affairs provided a verbal update on Governor Newsom's May Budget Revise. Mr. Roady discussed how the Department of Health Care Services (DHCS) has postponed the CalAIM due to the COVID-19 pandemic and noted that the Pharmacy Carve Out implementation remains on target to begin on January 1, 2021.

ADJOURNMENT

Chair Tolbert announced that the next MAC meeting is scheduled for Thursday, June 11, 2020 at 2:30 p.m.

Hearing no further business, Chair Tolbert adjourned the meeting at 5:02 p.m.

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

Approved: June 11, 2020

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Member Advisory Committee
FY 2019-20 Accomplishments

During FY 2019-20, the Member Advisory Committee (MAC) of the CalOptima Board of Directors provided input on member issues to ensure that CalOptima members receive high quality health care services. The following list highlights the accomplishments:

- MAC members reviewed the intergovernmental transfer (IGT) projects and supported the funding of the proposed programs, as well as the proposed recommendations for the use of the remaining IGT funds.

- MAC attended two joint meetings during FY 2019-2020. The first meeting was a joint meeting of all four Board Advisory Committees that was held on October 10, 2019 and the other was a joint meeting with the PAC on April 9, 2020 during a first ever virtual Gotowebinar meeting. MAC hopes to continue to share feedback with the other advisory committees on a yearly basis.

- Mallory Vega, the Seniors Representative on MAC continues to participate on the PACE Advisory Committee to provide input and reports to the Quality Assurance Committee of the Board regarding the PACE Center.

- MAC's Chair and Vice Chair were part of a joint recruitment ad hoc with members of PAC and OCC MAC to review the current structure of each committee and made recommendations as to seat descriptions for each of the committees. This joint committee recommended the renaming of two MAC seats, Medically Indigent and Persons with Mental Illness. The recommended name changes for these seats which was approved by the Board at their May 7, 2020 meeting, changing the name of of the seats to Behavioral/Mental Health Representative and Medical Safety Net Representative. MAC assisted PAC with revisions to their seat descriptions and created descriptions for MAC and OCC MAC .

- MAC held a special recruitment to identify candidates for for the Persons with Disabilities Representative. The MAC convened a special ad hoc committee to review the candidates for the vacant position and submitted their recommendation of Hai Hoang to the Board who appointed Mr. Hoang at their April 2, 2020 meeting.

- A MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates for the positions due to expire on June 30, 2020. The MAC reviewed the proposed candidates at its special May 14, 2020 MAC meeting and forwarded their recommendations to the Board for consideration and approval at its June 4, 2020 meeting.

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- MAC members and individuals from the community gave informative presentations at MAC meetings to help MAC stay connected to those they represent.

- Several MAC members attended CalOptima sponsored community education events, such as Community Alliance Forums and Awareness and Education Seminars and are part of committees such as the State Council on Developmental Disabilities, Regional Advisory Committee, OC HCA Mental Health Board, Orange County Adult Transition Task Force, CIE Blue Print Orange County Local Partnership Agreement Meetings, Postsecondary Education Transition Consortium (PSETC), SHIFT Parent Support Group and the Help Me Grow Connection Café.

- All MAC members completed the annual Compliance Training.

- Christine Tolbert, MAC Chair submitted and presented the MAC Report to the Board at six CalOptima's Board of Directors' meetings to provide the Board with input and updates on the MAC's current activities. Ms. Tolbert also attended and showed support at the Whole-Child Model Family Advisory Committee meetings.

- MAC member attendance equals on average over 76% of members attending each bi-monthly meeting. Currently there are 11 out of 15 members attending each meeting as several vacancies exist on the committee.

- MAC members contributed at least 232 official hours to CalOptima during FY 2019-20, including MAC meetings, ad hoc meetings, and Board meetings which is equivalent to 29 days per year. These hours do not account for the innumerable hours that MAC members dedicated to members on a day-to-day basis, nor the time spent preparing for meetings, and communicating with CalOptima.

- MAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2019–20.

The MAC thanks the CalOptima Board for the opportunity to provide updates on the MAC's activities. The MAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

Approved by: Member Advisory Committee – June 11, 2020

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MINUTES

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

May 14, 2020

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, May 14, 2020, at CalOptima, 505 City Parkway West, Orange, California and via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and consistent with Governor Newsom's executive orders EO-N-25-20 and EO-N-29-20, which temporarily relax the teleconferencing limitations of the Brown Act.

CALL TO ORDER

John Nishimoto, O.D., PAC Chair, called the meeting to order at 8:08 a.m. Vice Chair Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: John Nishimoto, O.D., Chair; Teri Miranti, Vice Chair; Anjan Batra, M.D.; Tina Bloomer, MHNP; Donald Bruhns; Andrew Inglis, M.D.; Jena Jensen; John Kelly, M.D.; Junie Lazo- Pearson, M.D.; Craig Myers; Pat Patton, MSN; Jacob Sweidan, M.D.; Loc Tran, Pharm.D.

Members Absent:

Others Present: Richard Sanchez, Interim Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; David Ramirez, M.D., Chief Medical Officer; Emily Fonda, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Candice Gomez, Executive Director, Program Implementation; Betsy Ha, Executive Director, Quality and Population Health Population Management; Tracy Hitzeman, Executive Director, Clinical Operations; Michelle Laughlin, Executive Director, Network Operations; TC Roady, Director, Regulatory Affairs; Betsy Ha, Executive Director, Population Health Management; Cheryl Simmons, Staff to the Advisory Committees; Samantha Fontenot, Program Assistant.

MINUTES

Approve Minutes of the March 12, 2020 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the March 12, 2020 regular meeting. (Motion carried 13-0-0)***

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Approve Minutes of the April 9, 2020 Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee and the Provider Advisory Committee.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the April 9, 2020 Special Joint meeting. (Motion carried 13-0-0)***

PUBLIC COMMENTS

There were no public comments.

REPORTS

Consider Approval of the FY 2020-2021 PAC Meeting Schedule

PAC members reviewed the proposed FY 2020-2021 meeting schedule. The PAC will meet on a monthly basis on the second Thursday of every month except during July 2020 and January 2021.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the PAC 2020-21 Meeting Schedule (Motion carried 13-0-0)***

Consider Recommendation of PAC Slate of Candidates

Chair Nishimoto summarized the recommendations of the PAC Nominations Ad Hoc Committee, which consisted of Chair, Dr. Nishimoto, Vice Chair, Miranti, and Dr. Lazo-Pearson. The ad hoc committee met on May 8, 2020 to review the 22 applications to fill the four expiring seats for Community Health Centers, Hospital, Physician, and Safety Net Representative, and the three applications for two open Allied Health Representative seats with terms through June 30, 2021 and June 30, 2022 respectively.

The ad hoc committee recommended the following candidates for the four expiring seats: Christy Ward (new appointment) as the Community Health Centers Representative, Jena Jensen (new appointment as the Hospital Representative; Alpesh Amin, M.D. (new appointment) as the Physician Representative and Alexander Rossel (new appointment) as the Safety Net Representative.

Action: ***On motion of Member Patton, seconded and carried, the Committee approved the Recommendation of PAC Slate of Candidates (Motion carried 13-0-0)***

Consider Recommendation of Allied Health Services Candidates

Chair Nishimoto reviewed the recommendations for the vacant two Allied Health Services Representatives to fill remaining terms. The ad hoc committee recommended Jennifer Birdsall, Ph.D. (new appointment) for a remaining term through June 30, 2022 and Peter Korchin (new appointment) for a remaining term through June 30, 2021 as Allied Health Services Representatives.

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Action: ***On motion of Member Patton, seconded and carried, the Committee approved the Recommendation of Allied Health Services Candidates (Motion carried 13-0-0)***

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Richard Sanchez, Interim Chief Executive Officer (CEO), provided an update on the CalOptima sub-committee that will be voting to appoint new CalOptima Board of Director's for the open Board seats. He noted the final vote will be held at the June 4, 2020 Board of Director's meeting. Mr. Sanchez also discussed COVID-19 testing availability within Orange County and the continued partnership with the Orange County Healthcare Agency (OCHCA) and other stakeholders. Mr. Sanchez also spoke about the anticipation leading up to Governor Newsom's May Revise of the California State budget and that it was expected to be released sometime during the morning.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer (COO), provided a verbal update noting that CalOptima is providing frequent fax blasts and email alerts to providers and health networks with informative updates regarding COVID-19. Ms. Khamseh noted that CalOptima's Customer Service Department is also outreaching to members to notify them of the availability of telehealth, mental health and prescription home delivery services.

Chief Medical Officer Update

David Ramirez, M.D., Chief Medical Officer, provided a brief update regarding the Department of Health Care Services (DHCS) modification to their Behavioral Health Incentive Program and noted that CalOptima is awaiting to hear an announcement sometime in mid-May. Dr. Ramirez also mentioned that the Trauma Informed Care Initiative which CalOptima continues to send educational tools to providers and the health networks for their use. Dr. Ramirez also noted that the Intergovernmental Transfer Funds (IGT) 9 were approved at the April 2, 2020 CalOptima Board of Director's Meeting.

INFORMATION ITEMS

Coronavirus (COVID-19) Update

David Ramirez M.D., Chief Medical Officer, provided an update on the COVID-19 pandemic and discussed CalOptima's COVID-19 response to date and noted that CalOptima continues to monitor and follow county and state public health guidance. Dr. Ramirez also discussed expanded testing for mildly symptomatic and asymptomatic individuals in Orange County and the role of telehealth with IGT-9 funds being used to launch a Virtual Care Strategy Plan which elicited many questions from the committee members.

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Virtual Care Strategy and Road Map Presentation

Betsy Ha, Executive Director, Quality and Population Health Management introduced Sajid Ahmed, CalOptima's virtual care consultant and CEO of WISE Healthcare. Mr. Ahmed gave an informational presentation on CalOptima's Virtual Care Strategy Plan that provided examples of virtual care modalities such as virtual visits and e-visits. Ms. Ha discussed CalOptima's Virtual Care Roadmap and guiding principles during and post COVID-19.

Federal and State Legislative Update

TC Roady, Director, Regulatory Affairs provided a verbal update on Governor Newsom's May Budget Revise and noted that DHCS is postponing the CalAIM implementation due to the COVID-19 pandemic but noted that the Pharmacy Carve Out implementation is still scheduled to take effect January 1, 2021.

PAC Member Updates

Chair Nishimoto reminded the Committee to submit their PAC accomplishments to Cheryl Simmons in preparation for the June 2020 Board Meeting. He also noted that PAC along with the MAC and OneCare Connect MAC will be scheduling a joint an ad hoc via Go-to Meeting in mid-June or July to formulate each committee's individual goals and objectives.

ADJOURNMENT

Chair Nishimoto announced that the next regular meeting would be held on Thursday, June 11, 2020.

Hearing no further business, Chair Nishimoto adjourned the meeting at 10:20 a.m.

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

Approved: June 11, 2020

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Provider Advisory Committee
FY 2019-20 Accomplishments

During FY 2019-2020 the CalOptima Board of Directors' Provider Advisory Committee (PAC) provided input on provider issues to ensure that CalOptima members continue to receive high quality health care services. The following list highlights their accomplishments:

- PAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan for five years in a row, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2019–20.

- Jacob Sweidan, M.D., one of the three PAC Physician Representatives serves on the CalOptima's Quality Improvement Committee (QIC). This committee provides overall direction for the continuous improvement process and oversees activities that are consistent with CalOptima's strategic goals and priorities; promotes an interdisciplinary approach to driving continuous improvement and makes certain that adequate resources are committed to the program; supports compliance with regulatory and licensing requirements and accreditation standards related to quality improvement projects, activities and initiatives; also monitors and evaluates the care and services members are provided to promote quality of care.

- Donald Bruhns, PAC's Long-Term Services and Supports (LTSS) Representative continues to participate in the Long-Term Services and Supports Quality Subcommittee (LTSS QISC). Mr. Bruhns role is to provide input into CalOptima's LTSS Quality Program. This has resulted in improvements to the quality metrics used to measure LTSS providers and the educational programs used to improve knowledge and services at the provider level.

- Teri Miranti PAC's Health Network Representative, shared information with all the health networks at the monthly Health Network Forum. Ms. Miranti continues to gather feedback from the health networks on topics to bring forward to the PAC for discussion. Topics included: rate discussions, Intergovernmental Transfer (IGT) funding, members experiencing homelessness, Proposition 56 (Tobacco Tax) and COVID-19 updates.

- PAC's Behavioral Health Representative Junie Lazo-Pearson, Ph.D., met with Orange County providers during the months of August, November and February. During COVID-19 and the transition to telehealth with our providers, Dr. Lazo-Pearson reached out and communicated CalOptima's initiatives in response to COVID-19 and its impact on the behavioral health community they represent.

- PAC's Pharmacy Representative Loc Tran, PharmD has used the monthly PAC meetings as a platform to deliver pharmacy-related topics/information to the active members of the California Pharmacist Association in Orange County. In addition to Dr. Tran's communications with various

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pharmacist associations, he is directly involved with the care for CalOptima members living at various homeless shelters throughout the County. On a daily/weekly basis, he advocates on behalf of CalOptima's homeless patients in transitional care settings such as shelters. During the COVID-19 pandemic his biggest focus has been on the care of "high risk" members.

- All PAC members completed the annual Compliance Training for 2019-20 by the required deadline.

- PAC attended two joint meetings during FY 2019-2020. The first meeting was a joint meeting of all four Board Advisory Committees that was held on October 10, 2019 and the other was a joint meeting with the MAC on April 9, 2020 during a first ever virtual Gotowebinar meeting. PAC hopes to continue to share feedback with the other advisory committees on a yearly basis.

- The 2020 PAC Nomination Ad Hoc subcommittee met on May 8, 2020 to recommend a slate of candidates for the six PAC vacancies consisting of two Allied Health Services Representatives, Community Health Centers Representative, Hospital Representative, Physician Representative and the Safety Net Representative. The ad hoc reviewed 22 applications for the open seats. The ad hoc members presented the slate of candidates to the full PAC on May 14, 2020 with their recommendations. PAC members also assisted by reaching out to their constituents to help fill these vacancies.

- Three PAC members were part of a joint recruitment ad hoc with members of MAC and OCC MAC to review the current structure of each committee and make recommendations as to seat descriptions for each of the committees. This committee recommended the reclassification of one of the two Long-Term Services and Supports seat to an Allied Health Services seat which was approved by the Board at their April 2, 2020 meeting, revised the name of the Traditional Safety Net Representative to Safety Net Representative and revised the seat descriptions while also assisting MAC and OCC MAC write seat descriptions.

- PAC members continued to support and provide input into Intergovernmental Transfer (IGT) projects that are currently in process, as well as the proposed recommendations for the use of IGT funds currently under consideration.

- John Nishimoto, O.D., PAC Chair submitted and presented the PAC Report to the Board at 10 CalOptima's Board of Directors' meetings to provide the Board with input and updates on the PAC's current activities.

- The PAC Chair solicited discussion topics/presentations from other PAC members which led to sharing their expertise about cutting edge programs being developed. The Chair and Vice Chair monitored and documented the quarterly PAC Goals and Objectives. The Chair and Vice Chair spent on average three hours a month working with the Staff to the Advisory Committees to formalize the meeting agenda and review and edit PAC's Report to the Board.

- PAC member attendance equals on average over 71% of members attending each monthly meeting. Currently there are 13 out of 15 members attending each meeting. PAC welcomed Andrew Inglis, M.D. as the Orange County Health Care Agency representative at their February meeting. PAC

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actively recruited for two Allied Health Services Representatives which were appointed in June 2020 to fulfill remaining terms.

- Two PAC members arranged and made presentations to the PAC and one PAC member arranged for all four Board committees to hear about a state-of-the-art autism center with individual presentations to the committees.

- Including the monthly PAC meetings during FY 2019-2020, PAC members have participated in at least three (3) ad hoc subcommittees and dedicated approximately 276 hours or the equivalent of 35 business days to PAC endeavors. This does not account for the time spent preparing for meetings, reviewing reports, participating in their professional associations and communicating with CalOptima staff and their respective constituencies.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities during the monthly Board Meetings. In addition, the PAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

Approved by: Provider Advisory Committee - June 11, 2020

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Authorizing Execution of Amendments to the Primary Agreement with the California Department of Health Care Services

Contact

Silver Ho, Executive Director, Compliance (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an amendment to the Primary Agreement between DHCS and CalOptima related to the incorporation of language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule (Final Rule).

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Amendment for the Medicaid and CHIP Managed Care Final Rule (Final Rule)

On May 6, 2016, the Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP), Managed Care Final Rule, CMS 2390–F (Final Rule). The Final Rule contains various provisions that State Medicaid Agencies, including DHCS, were required to implement by various deadlines, beginning in July 2017. Authority to execute 2017 Final Rule Amendment was granted to the Chair during the meetings of the CalOptima Board of Directors on December 5, 2019 and February 6, 2020.

On March 18, 2019, DHCS informed Plans that it will submit an amendment to CMS for approval to bring its contracts with managed care plans (MCPs) into alignment with the requirements set forth in the Final Rule effective July 1, 2018.

DHCS implemented the requirements of the Final Rule through the issuance of sub-regulatory guidance such as All-Plan Letters (APLs). Simultaneously, DHCS has been working with CMS to formalize the requirements in DHCS's contracts with the MCPs, including CalOptima. Due in part to the lengthy CMS review process, DHCS implemented these requirements prior to their formal inclusion in MCP contracts.

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This 2018 Final Rule amendment addresses the following provisions:

- Network Data Reporting;
- External Quality Review Requirements;
- Provider Network;
- Annual Network Certification; and
- Provider Screening and Enrollment.

Once CMS approves DHCS's proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature and return. If the amendment is not consistent with Staff's understanding as presented in this document or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for further consideration.

What follows is a general summary of the major changes contained within the 2018 Final Rule amendment:

	Requirement	**Sub-Regulatory Guidance**
Network Data Reporting	Ensure complete, accurate, reasonable, and timely submission of network data to DHCS representing CalOptima's network.	DHCS All–Plan Letter (APL) 20–003: Network Certification Requirements
External Quality Review Requirements	Ensure compliance with external quality review requirements including, but not limited to: • Managed Care Accountability Set (MCAS) measures • Performance Improvement Projects (PIPs) • Network adequacy validation • Encounter data validation • Focused studies • Technical assistance	DHCS All-Plan Letter (APL) 19-017 Quality and Performance Improvement Requirements DHCS All-Plan Letter (APL) 20-003: Network Certification Requirements
Provider Network	Maintain an adequate network of adult and pediatric providers located	DHCS All–Plan Letter (APL) 20–003: Network Certification Requirements

	within provider-specific time and distance standards.	
Annual Network Certification	Submission of the annual network certification to DHCS demonstrating capacity to serve current and expected membership in CalOptima's service area.	DHCS All–Plan Letter (APL) 20–003: Network Certification Requirements
Provider Screening and Enrollment	Screen and enroll all network providers in accordance with federal requirements and DHCS APLs.	DHCS All–Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

It is important to note that the 2018 Final Rule Amendment simply formalizes changes that DHCS has already implemented via the sub-regulatory guidance outlined above. At this time, the amendment does not contain any rate changes or otherwise set any rates.

Fiscal Impact
The recommended action to execute the amendment of the Primary Agreement between DHCS and CalOptima is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of the provisions for the 2018 Final Rule amendments to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule and for the continued operation of CalOptima's Medi-Cal program.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Appendix summary of amendments to Primary Agreements with DHCS
2. SFY 18-19 Amendment-Final-MCP Copy_1-14-19

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 3

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

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

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Amendments to Primary Agreement	Board Approval
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014

Amendments to Primary Agreement	Board Approval
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-45 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013

A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

V. Exhibit A, Attachment 3, MANAGEMENT INFORMATION SYSTEM, is amended to add:

6. Network Data Submissions

Contractor shall maintain a health information system that collects and reports Network data to DHCS in compliance with 42 CFR 438.207, 438.604(a)(5), 438.606, and in accordance with APL 18-005.

A. Contractor shall ensure the complete, accurate, reasonable, and timely submission of Network data to DHCS for all data that represents Contractor's Network, whether through direct Subcontracts, a Subcontractor's network, or other arrangements. Network data shall be submitted on at least a monthly basis in the form and manner specified by DHCS.

B. Contractor shall require subcontracting Providers to submit Network data to Contractor to meet its administrative functions and the requirements set forth in this Provision. Contractor shall have in place mechanisms, including edit and reporting systems sufficient to assure Network data is complete, accurate, reasonable, and timely prior to submission to DHCS. Contractor shall ensure the completeness, accuracy, reasonability, and timeliness of all Subcontractor provider network data regardless of contracting arrangements.

C. Contractor shall submit complete, accurate, reasonable, and timely Network data within ten (10) calendar days following the end of each month under this Contract or as otherwise agreed upon by DHCS, and in the format specified by DHCS. Contractor shall certify all Network data as set forth in 42 CFR 438.606.

D. DHCS shall review and validate Network data for completeness, accuracy, reasonability, and timeliness. If DHCS finds deficiencies regarding the completeness, accuracy, reasonability, and timeliness of the Network data, DHCS may notify Contractor in writing of the deficiency and request correction and resubmission of the relevant data. Contractor shall ensure that corrected Network data is resubmitted within 15 calendar days of the date of the DHCS

notice. Upon Contractor's written request, DHCS may grant an extension for submission of corrected Network data.

VI. Exhibit A, Attachment 4, QUALITY IMPROVEMENT SYSTEM, is amended to read:

9. External Quality Review Requirements

At least annually or as designated by DHCS, DHCS shall arrange for External Quality Review of Contractor by an entity qualified to conduct such reviews in accordance with Title 22 CCR Section 53860(d), Title 42, USC, Section 1396u-2(c)(2), and 42 CFR 438.350, 438.358, and 438.364. Contractor shall cooperate with and assist the External Quality Review Organization (EQRO) contracted with DHCS in the conduct of this review. **Contractor shall comply with the following requirements, as well as the activities specified in APL 17-014, including the external quality review protocol issued by CMS which provides detailed instructions on how to complete the activities.**

A. External Accountability Set (EAS) Performance Measures

The EAS performance measures consist of a set of Healthcare Effectiveness Data and Information Set (HEDIS®) measures developed by the National Committee for Quality Assurance (NCQA). The EAS performance measures may also include other standardized performance measures and/or DHCS developed performance measures selected by DHCS for evaluation of health plan performance.

~~1) On an annual basis, Contractor shall submit to an on-site EAS Compliance Audit (previously referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the Contractor's information and reporting systems, as well as the Contractor's methodologies for calculating performance measure rates. Contractor shall use the DHCS-selected contractor for performance of the EAS/HEDIS Compliance Audit and calculation of DHCS-developed performance measures that constitute the EAS. Compliance Audits will be performed by an EQRO as contracted and paid for by the State.~~

~~2) Contractor shall calculate and report all EAS performance measures at the county level.~~

~~a) HEDIS rates are to be calculated by the Contractor and verified by the DHCS-selected EQRO. Rates for other standardized and/or DHCS-developed performance measures will be calculated by the Contractor, DHCS staff or the EQRO, as directed by DHCS.~~

~~b) Contractor shall report audited results on the EAS performance measures to DHCS no later than June 15 of each year or such date as established by DHCS. Contractor shall initiate reporting on EAS performance measures for the reporting cycle following the first year of operation.~~

~~3) Contractor shall meet or exceed the DHCS-established Minimum Performance Level (MPL) for each HEDIS measure, and any other EAS performance measures required pursuant to of this Provision.~~

~~a) For each measure that does not meet the MPL set for that year, or is reported as a "Not Report" (NR) due to an audit failure, Contractor must submit a plan outlining the steps that will be taken to improve the subsequent year's performance.~~

~~b) The improvement plan must include, at a minimum, identification of the team that will address the problem, a root cause analysis, identification of interventions that will be implemented, and a proposed timeline.~~

~~c) Improvement plans are due to the DHCS within 60 calendar days of the DHCS' notification that the Contractor has performed at or below the MPL for the period under review.~~

~~d) Additional reporting may be required of the Contractor until such time as improvement is demonstrated.~~

B. Under/Over-Utilization Monitoring

In addition to the EAS performance measures, Contractor shall submit to an audit of, and report rates for, an Under/Over-Utilization Monitoring Measure Set based upon selected HEDIS Use of Service measures or any other standardized or DHCS-developed utilization measures selected by DHCS. These measures may be

audited as part of the EAS/HEDIS Compliance Audit, and these rates shall be submitted with the EAS audited rates or separately as directed by DHCS. DHCS will bear the costs associated with the Compliance Audit as performed by the contracted EQRO. The measures selected for inclusion in the set will be chosen by DHCS on an annual basis. By August 1 of each year, DHCS will notify Contractors of the HEDIS and other EAS performance measures selected for inclusion in the following year's Utilization Monitoring measure set.

C. Performance Improvement Projects (PIPs)

1) For this Contract, Contractor is required to conduct or participate in **PIPs, including any PIP required by CMS, in accordance with 42 CFR 438.330. Contractor shall conduct or participate in, at a minimum,** two (2) PIPs per year, **as** approved by DHCS. If Contractor holds multiple managed care contracts with DHCS, Contractor is required to conduct or participate in two PIPs for each contract. At its sole discretion, DHCS may require Contractor to conduct or participate in additional PIPs.

~~a) One PIP must be either an internal performance improvement project (IPIP) or a small group collaborative (SGC) facilitated by a health plan or DHCS. The SGC must include a minimum of four (4) DHCS health plan contactors and must use standardized measures and clinical practice guidelines. Additionally, all contracting health plans participating in a SGC must agree to the same goal, timelines for development, implementation, and measurement. Contracting health plans participating in a SGC must also agree on the nature of contracting health plan commitment of staff and other resources to the collaborative project.~~

~~b) One PIP must be a DHCS facilitated Statewide Collaborative. If the Contract operation start date of this Contract is after the Statewide Collaborative has begun implementation, upon DHCS's approval, Contractor may substitute a SGC and/or IPIP in place of the Statewide Collaborative.~~

~~2) If this Contract covers multiple counties, Contractor must include all counties in a PIP unless otherwise approved by DHCS.~~

~~3~~**2**) Contractor shall comply with APL ~~16-018~~ **17-014**, as well as any subsequent updates, and shall use the PIP reporting format as designated therein to request approval of proposed PIPs from DHCS and to report at least annually to DHCS on the status of each PIP. ~~The required documentation for PIP proposals and for PIP status reports shall include but is not limited to:~~

~~a) In-depth qualitative and quantitative analysis of barriers and results.~~

~~b) Evidence-based interventions and best practices, when available, and system-wide intervention, when appropriate.~~

~~c) Interventions that address health disparities.~~

~~d) Measurement of performance using objective quality indicators.~~

~~e) Strategies for sustaining and spreading improvement beyond the duration of the PIP.~~

D. Consumer Satisfaction Survey

At intervals as determined by DHCS, DHCS' contracted EQRO will conduct a consumer satisfaction survey of a representative sample of members enrolled in Contractor's plan in each county, as determined by the technical specifications of the survey instrument chosen by DHCS. If requested, Contractor shall provide appropriate data to the EQRO to facilitate this survey.

E. Network Adequacy Validation

Contractor is required to participate in the validation of Network adequacy from the preceding 12 months to comply with requirements set forth in 42 CFR 438.68 and 42 CFR 438.14(b)(1).

F. Encounter Data Validation

At intervals determined by DHCS, its contracted EQRO will conduct a validation of Encounter Data assessing the

completeness, accuracy, reasonability, and timeliness of Encounter Data submitted by Contractor to DHCS.

G. Focused Studies

DHCS may choose to conduct an external review of focused clinical and/or non-clinical topic(s) as part of its review of quality outcomes and timeliness of, and access to, services provided by Contractor.

H. Technical Assistance

In accordance with 42 CFR 438.358(d) and at the direction of DHCS, the EQRO may provide technical guidance to Contractor as described in 42 CFR 438.310(c)(2) in order to assist Contractor in conducting mandatory and optional activities described in 42 CFR 438.358 and this Contract regarding information for the EQR and the resulting EQR technical report.

VII. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

2. Network Composition

Within each Service Area, Contractor shall ensure and monitor an appropriate Provider Network, including**, but not limited to,** adult and pediatric PCPs, OB/GYN, adult and pediatric behavioral health Providers, adult and pediatric Specialists, professional, Allied Health Personnel, supportive paramedical personnel, hospitals, pharmacies and an adequate number of accessible inpatient facilities and service sites. In addition, Contractor shall ensure and monitor MLTSS Providers, American Indian Health Service Programs, Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and Freestanding Birthing Centers (FBCs), where available. **Contractor shall submit assurances to DHCS regarding its Network composition in accordance with 42 CFR 438.207.**

VIII. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

6. Specialists

Contractor shall maintain **an** adequate ~~numbers and types of~~ **Network that includes adult and pediatric** Specialists**, and at a minimum, core Specialists as described in Welfare and Institutions Code, Section**

14197(h)(2), within their Network to accommodate the need for specialty care in accordance with Title 22 CCR Section 53853(a)**,** and ~~W & I~~ **Welfare and Institutions** Code**,** ~~section~~ **Sections** 14182(c)(2) **and 14087.3**.

IX. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to read:

8. Time and Distance Standard

Contractor shall maintain a Network of **adult and pediatric** PCPs**, adult and pediatric core Specialists, OB/GYN primary and specialty care, mental health Providers, hospitals, and pharmacies** which are located within ~~30 minutes or 10 miles of a Member's residence~~ **the provider-specific time and distance standard as required in Welfare and Institutions Code, Sections 14197(b) and (c),** unless Contractor has a DHCS-approved alternative time and distance standard **in accordance with Welfare and Institutions Code, Section 14197(e), and as decided and modified by DHCS**. **DHCS will evaluate and approve exceptions to the Network standard by Provider type and for all Provider types covered under this Contract. For MLTSS, Contractor shall adhere to timely access standards in accordance with Welfare and Institutions Code, Section 14197(d)(2).**

Commented [ACR(1]: Include this requirement in CCI plan contracts; exclude from non-CCI plan contracts.

X. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to add:

11. Provider Network Reports

Contractor shall submit to DHCS, in a format specified by DHCS, a report summarizing changes in the Provider Network.

A. The report shall be submitted at a minimum:

1) Quarterly

2) At the time of a ~~significant change~~ **Significant Change, as defined in this Contract and set forth in 42 CFR 438.207 and APL 18-XXX,** to the Network affecting Provider capacity and services, including:

a) Change in services or benefits;

b) Geographic service area or payments; or

c) **The composition of, or the payments to, it's Network; or**

d) Enrollment of a new population.

B. The report shall identify number of Primary Care Providers, Provider deletions and additions, and the resulting impact to:

1) Geographic access for the Members;

2) Cultural and linguistic services including Provider and Provider staff language capability;

3) The percentage of Traditional and Safety-Net Providers;

4) The number of Members assigned to each Primary Care Physician;

5) The percentage of Members assigned to Traditional and Safety-Net Providers; and

6) The Network Providers who are not accepting new patients.

C. Contractor shall submit the report 30 calendar days following the end of the reporting quarter.

D. Contractor shall participate annually in the submission to DHCS of its Provider Network composition report to demonstrate its capacity to serve the current and expected membership in its Service Area in accordance with State standards for access and timeliness of care, 42 CFR 438.207(b), and APL 18-005.

XI. Exhibit A, Attachment 6, PROVIDER NETWORK, is amended to add:

20. Provider Screening and Enrollment

All Network Providers must be screened and enrolled in accordance with Title 42 CFR 438.602(b), and APL 17-019. Contractor must screen and enroll Provider types that are not currently enrolled in Medi-Cal FFS if those Provider types are necessary to maintain an adequate Network. Contractor shall implement and maintain requirements for the screening and enrollment of Network Providers and shall submit them to DHCS for review and approval.

XII. Exhibit A, Attachment 10, SCOPE OF SERVICES, is amended to read:

5. Services for Members under Twenty-One (21) Years of Age

Contractor shall cover and ensure the provision of screening, preventive and Medically Necessary diagnostic and treatment services for Members under 21 years of age including services listed under 42 USC Section 1396d(r), and W & I Code section 14132(v), unless otherwise excluded under this Contract.

Contractor shall ensure that appropriate diagnostic and treatment services are initiated as soon as possible but no later than 60 calendar days following either a preventive screening or other visit that identifies a need for follow-up.

G. Behavioral Health Treatment (BHT) Services

For Members under 21 years of age ~~diagnosed with Autism Spectrum Disorder (ASD), or for Members under 3 years of age with a rule out or provisional diagnosis~~, Contractor shall cover Medically Necessary BHT services as **required in Section 1905(r) of the Social Security Act under the Early and Periodic Screening, Diagnostic and Treatment benefit,** defined in the federally approved State Plan, and in accordance with **Welfare and Institutions Code Section 14132.56,** Health and Safety Code ~~s~~**S**ections 1374.72 and 1374.73, 28 ~~California Code of Regulations~~ **CCR** 1300.74.72, ~~APL 15-019, and APL 15-025~~ **and APL 18-006, and APL 18-008** ~~to the extent that they are consistent with the State Plan~~. **These** APLs**,** ~~superseding APL 15-019 and APL 15-025 that~~ **as identified in this Provision,** clarify the delivery of BHT services **and** shall be incorporated herein by this reference and become part of this Contract as of their effective date.

1) Contractor shall provide Medically Necessary BHT services **in accordance with recommendation from a licensed Physician and surgeon, or a licensed psychologist** as stated in the Member's treatment plan and/or continuation of BHT services under continuity of care ~~with the Member's BHT Provider~~.

~~2) For Members 3 years or older, Contractor shall require a Comprehensive Diagnostic Evaluation before Members receive BHT services.~~

~~3~~**2**) ~~BHT services must be based upon a~~ **The behavioral** treatment plan ~~that is~~ **must be** reviewed**, revised, and/or modified** no less than every six (6) months by a ~~qualified autism~~ **a BHT** service Provider as defined by Health and Safety Code Section 1374.73(c)(3) and by the federally approved State Plan **Amendment**. **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.**

~~4~~ **3**) Contractor shall provide continuity of care for Members ~~diagnosed with ASD~~ **who are transitioning from the regional centers to receive Medically Necessary BHT services** as stated ~~below and in accordance with this Section~~ **in Paragraph** G**.3) of this Provision**.

a) ~~For Members who had received BHT through a regional center prior to September 15, 2014,~~ Contractor shall not provide **Medically Necessary** BHT services until such time as the Member may be safely transitioned into Contractor's Provider Network in accordance with the BHT services transition plan approved by DHCS and the Department of Developmental Services (DDS). If a Member, or a Member's parent or legal guardian, chooses to access **Medically Necessary** BHT services from Contractor's Network Provider prior to the transition of regional center clients to the Contractor for BHT services, Contractor shall provide Medically Necessary BHT services from Contractor's Network Provider.

b) For Members without an Autism Spectrum Disorder (ASD) diagnosis who had received BHT services through a regional center, Contractor shall not provide Medically Necessary BHT services until July 1, 2018, or the date the transition of regional center clients to Contractor for Medically Necessary BHT services occurs. Members may not access Medically Necessary BHT services from Contractor's Network Provider prior to the transition.

~~b~~**c**) If Members received BHT services outside of Contractor's Network prior to ~~September 15, 2014~~ **the**

transition date, and the Member or the Member's parent or legal guardian request continued access to their existing BHT Provider, Contractor shall ensure continuity of care in accordance with ~~APL 15-019 and APL 15-025~~ **APL 18-006 and APL 18-008.** Contractor must offer continuity of care with an out-of-Network BHT Provider if all of the following conditions are met:

i. The Member has an existing relationship with a ~~qualified autism service~~ Provider. An existing relationship means the Member has seen an out-of-Network BHT Provider at least one **(1)** time during the six (6) months prior to Contractor assuming responsibility of BHT services from the regional center or the date of the Member's initial enrollment with Contractor if enrollment occurred on or after September 15, 2014;

ii. The Provider ~~can agree~~ **agrees** to Contractor's rate or the Medi-Cal FFS rate, whichever is higher, for the appropriate BHT service;

iii. The Provider does not have any documented quality of care issues that would cause exclusion from Contractor's Network;

iv. The Provider is a qualified Provider under Health & Safety Code Section 1374.73 and the approved State Plan **Amendment**; and

v. The Provider supplies Contractor with all relevant treatment information, for purposes of determining medical necessity, as well as a current treatment plan, as long as it is allowable under federal and state privacy laws and regulations.

~~c~~**d**) Contractor shall continue to authorize Medically Necessary BHT services in accordance with the Member's treatment plan at the time of the request for continuity of care during the continuity of care period **as described in APL 18-006**.

~~d~~**e**) Contractor's Network Provider may update the BHT treatment plan upon completion of ~~the~~ **an** assessment

and discontinue BHT services if the evaluation determines that ~~the authorization of~~ BHT services ~~is~~ **are** not Medically Necessary.

~~5~~**4**) Contractor shall provide all necessary Member treatment information to the Member's regional center to enable care coordination, as permitted by federal and State law, APL ~~15-022~~ **18-009**, and this Contract.

~~6~~**5**) Contractor shall enter into a Memorandum of Understanding (MOU) with each local regional center in accordance with Exhibit A, Attachment 12, Provision 2 of this Contract, to facilitate the coordination of services for Members with developmental disabilities, including ASD, as permitted by federal and State law, and specified by DHCS in APL ~~15-022~~ **18-009**. If Contractor is unable to enter into an MOU, Contractor shall inform DHCS why agreement with the regional center was not reached and demonstrate that a good faith effort was made by Contractor to enter into an MOU with the regional center.

XIII. Exhibit A, Attachment 10, COVERED SERVICES

Commented [ACR(2]: For Two-Plan and Regional Model contracts only.

6. Services for Adults

C. Immunizations

Contractor is responsible for assuring that all adults are fully immunized. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most ~~current California Adult Immunization~~ **recent** recommendations **published by ACIP**.

In addition, Contractor shall cover and ensure the provision of age and risk appropriate immunizations in accordance with the findings of the IHA, other preventive screenings and/or the presence of risk factors identified in the health education behavioral assessment.

Contractor shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate Contractor's

unsuccessful efforts to provide the immunization shall be considered evidence in meeting this requirement.

XIV. Exhibit A, Attachment 17, REPORTING REQUIREMENTS, is amended to read:

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure Form)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		
2. Financial Audit Reports B. 1) **or** B. 2)	Annual certified Financial Statements and DMHC required reporting forms **or** Financial Statement	Annually
2. Financial Audit Reports B. 2)	Quarterly Financial Reports	Quarterly
4. Monthly Financial Statements	Monthly Financial Statements (If applicable)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal C.	Encounter Data Submittal	Monthly
6. Network Data Reporting	**Network Data Submittal in the 274 Provider File**	**Monthly**
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee C.	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set (EAS) Performance Measures 2) b)	EAS Performance Measurement Rates	Annually
9. External Quality Review Requirements B. Under/Over-Utilization Monitoring	Reported rates	Annually
9. External Quality Review Requirements C. Performance Improvement Projects (PIPs)	PIP Proposals or Status Reports	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		

Contract Section	Requirement	Frequency
11. Provider Network Report**s** **A.** **B.** **C.**	Provider Network **Changes** Report	Quarterly
11. Annual Provider Network Report	**Provider Network Capacity Report**	**Annually**
12. Plan Subcontractors	Plan Subcontractors Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
13. Cultural and Linguistic Program C. Group Needs Assessment 4)	Group Needs Assessment Summary Report	Every 5 years
Attachment 10 SCOPE OF SERVICES		
5. Services for Members under Twenty-One (21) Years of Age B. Children's Preventive Services 5)	Confidential Screening/Billing Report Form~~, PM 160 PHP~~	Monthly
5. Services for Members under Twenty-One (21) Years of Age G. Behavioral Health Treatment Services	BHT Reporting Template	~~First Six Months: Monthly~~ ~~After Six Months:~~ Quarterly
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 5)	Report of Changes to the Formulary	Annually
8. Services for All Members G. Pharmaceutical Services and Provision of Prescribed Drugs 7)	Report of DUR Program Activities	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION		
4. MOU Monthly Reports	Local Health Department - MOU's County Mental Health - MOU's (If deemed necessary)	Monthly **until MOU is signed**
Attachment 13 MEMBER SERVICES		
3. Call Center Reports	Call Center Reports	Quarterly
4. Written Member Information B.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEVANCE AND APPEAL SYSTEM		
3. Grievance and Appeal Log and Quarterly Grievance and Appeal Report	Grievance and Appeal Report	Quarterly

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Contract Section	Requirement	Frequency
Attachment 15 MARKETING		
3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENTS AND DISENROLLMENTS		
1. Enrollment Program (PL 11-009)	Provider Directory	Semi-Annually
Attachment 19 COMMUNITY BASED ADULT SERVICES (CBAS)		
5. Required Reports for the CBAS Program A.	Provision of ECM Report	Quarterly
5. Required Reports for the CBAS Program B.	CBAS Enrollment Report	Quarterly
5. Required Reports for the CBAS Program C.	Addition to Call Center Report	Quarterly
5. Required Reports for the CBAS Program D.	Addition to Grievance and Appeal Report	Quarterly
Attachment 20 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS		
3. Provider Network Reports A.	Addition to the Provider Network Report	Quarterly
3. Provider Network Reports B.	Outpatient Mental Health Services Providers Report	Monthly
Attachment 21 MANAGED LONG-TERM SERVICES AND SUPPORTS (MLTSS)		
10. Required Reports for Managed Long Term Services and Supports A.	Support and Retention of Community Placement	Quarterly
10. Required Reports for Managed Long Term Services and Supports B.	Continuity of Care Requests	Monthly
10. Required Reports for Managed Long Term Services and Supports C.	Addition to the Provider Network Report	Quarterly
10. Required Reports for Managed Long Term Services and Supports D.	Addition to Call Center Reports	Quarterly
10. Required Reports for Managed Long Term Services and Supports E.	Addition to Grievances and Appeals Report	Monthly
10. Required Reports for Managed Long Term Services and Supports F.	PCP Assignment	Monthly
Exhibit B - BUDGET DETAIL AND PAYMENT PROVISIONS		
12. Payment of Aids Beneficiary Rates A. Compensation at the AIDS Beneficiary Rate (ABR) 1) c)	AIDS Beneficiaries Rate (ABR) Invoice	Monthly

Contract Section	Requirement	Frequency
Exhibit E - ADDITIONAL PROVISIONS		
Attachment 2 PROGRAM TERMS AND CONDITIONS		
34. Treatment of Recoveries C. Recovery of Overpayment	Recovery of Overpayment Report	Annually

XV. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to add:

3. Management Information System (MIS)

J. Submit policies and procedures for the submission of complete, accurate, reasonable, and timely Network data to DHCS.

XVI. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

4. Quality Improvement System

H. Policies and procedures to address how the Contractor will meet the requirements of:

1) External Accountability Set (EAS) Performance Measures

2) Performance Improvement Projects

3) Consumer Satisfaction Survey

4) Network Adequacy Validation

5) Encounter Data Validation

6) Focused Studies

7) Technical Assistance

XVII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

5. Utilization Management (UM)

A. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services**, including the processes to be used for the provision of Medically Necessary Behavioral Health Treatment (BHT) services**.

XVIII. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

6. Provider Network

A. Submit complete Provider Network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries, including SPD beneficiaries, in the county pursuant to the Contract.

B. Submit policies and procedures describing how Contractor will monitor Provider to patient ratios to ensure they are within specified standards.

C. Submit policies and procedures regarding physician supervision of Non-Physician Medical Practitioners.

D. Submit policies and procedures for providing emergency services.

E. Submit a complete list of Specialists by type within ~~the~~ Contractor's Network **in accordance with Welfare and Institutions Code, Section 14087.3**.

F. Submit policies and procedures for how Contractor will meet federal requirements for access and reimbursement to Network and/or out-of-Network Federally Qualified Health Center (FQHC), Rural Health Clinic (RHC), and Freestanding Birthing Center (FBC) services.

G. Submit a GeoAccess report (or similar) showing that the proposed Provider Network meets the appropriate time and distance standards set forth in the Contract.

H. Submit a policy regarding the availability of a health plan physician 24-hours-a-day, 7-days-a-week, and procedures for communicating with emergency room personnel.

I. Submit policies and procedures for how Contractor will ensure Network Provider hours of operation are no less than the hours of operation offered to other commercial or FFS patients.

J. Submit a report containing the names of all subcontracting Provider groups (see Exhibit A, Attachment 6, Provision ~~11~~**12**).

K. Submit an analysis demonstrating the ability of the Contractor's Provider Network to meet the ethnic, cultural, and linguistic needs of Contractor's Members.

L. Submit policies and procedures for ensuring Subcontractors fully comply with all terms and conditions of this Contract.

M. Submit all boilerplate Subcontracts.

N. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.

O. Submit an attestation as to the percentage of Traditional and Safety-Net Providers in the Contractor's Network and agreement to maintain that percentage.

P. Submit policies and procedures for the screening and enrollment of Network Providers.

XIX. Exhibit A, Attachment 18, IMPLEMENTATION PLAN AND DELIVERABLES, is amended to read:

10. Scope of Services

E. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:

1) Children's preventive services

2) Immunizations

3) Blood Lead screens

4) Screening for Chlamydia

5) EPSDT services

6) Medically Necessary BHT services

XX. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to read:

4. Capitation Rates

A. DHCS shall remit to Contractor a Capitation Payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by DHCS. The capitation rate shall be the amount specified below. The payment period for health care services shall commence on the first day of operations, as determined by DHCS. Capitation Payments shall be made in accordance with the following schedule of Capitation Payment rates at the end of the month. For aid codes see DEFINITIONS, Eligible Beneficiary:

For the period 07/01/18 – 06/30/19	**County**
Groups	**Rates**
Adult & Family/Optional Targeted Low-Income Child (Under 19)	
Adult & Family/Optional Targeted Low-Income Child (19 & Older)	
Family & Dual Eligible	
SPD/Medi-Cal Only	
SPD/Dual Eligible	
Long Term Care/Medi-Cal Only	
Long Term Care/Dual Eligible	
Breast and Cervical Cancer Treatment Program (BCCTP)	
Maternity	
Adult Expansion	
Maternity Expansion	
Hepatitis C/340B	
Hepatitis C/Non-340B	
HCBS High	
HCBS Low	
BHT/Ages 0-6	
BHT/Ages 7-20	
American Indian Health Service Programs	
[Health Homes Program – Selected Plans]	
[**Whole Child Model**-Selected COHS Only]	

XXI. Exhibit E, Attachment 1, DEFINITIONS, is amended to add:

Behavioral Health Treatment (BHT) means ~~services approved in the State Plan such as Applied Behavior Analysis (ABA) and other~~ **Medically Necessary,**

evidence-based behavioral interventions to ~~prevent or minimize the adverse effects of ASD and~~ promote, to the maximum extent practicable, the functioning of a Member. These services are interventions designed to treat ~~ASD, and include~~ **behavioral 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.

BHT Provider means a Qualified Autism Services (QAS) Provider, Professional, or Paraprofessional, as defined within the State Plan Amendment.

Eligible Beneficiary means any Medi-Cal beneficiary who is residing in ~~the~~ Contractor's Service Area with one of the following aid codes:

Aid Group	Mandatory Aid Codes	Non-Mandatory Aid Codes
Adult & Family/Optional Targeted Low-Income Child	01, 02, 08, 0A, 0E, 30, 32, 33, 34, 35, 37, 38, 39, 3A, 3C, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, **5L,** 72, 7A, 7J, 7S, 7W, 7X, 82, 8P, 8R, **8U,** E2, E5, K1, M3, M7, P5, P7, P9, 5C, 5D, E6, E7, H1, H2, H3, H4, H5, M5, **R1,** T1, T2, T3, T4, T5	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 86, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, **5L**
Family/Dual Eligible	0E, 30, 32, 33, 34, 35, 37, 38, 39, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 47, 54, 59, **5L,** 72, 7A, 7J, 7W, 7X, 82, 8P, 8R, **8U,** E2, E5, K1, M3, M7, P5, P7, P9**, R1**	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 4A, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4W, 5K, **5L**
SPD	10, 14, 16, 1E, 1H, 20, 24, 26, 2E, 2H, 36, 60, 64, 66, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V**, L6**	
Adult Expansion	L1, M1, 7U	
Breast and Cervical Cancer Treatment Program (BCCTP)		0N, 0P, 0W
Long Term Care/Full Dual Eligible	13, 23, 63	

Commented [ACR(4]: Voluntary in Two-Plan, GMC, Regional, Imperial, and San Benito plans.

Commented [ACR(3]: Mandatory for COHS only.

Long Term Care/ Non-Full Dual Eligible	13, 23, 63	
SPD/Dual Eligible	10, 14, 16, 17, 1E, 1H, 1X, 1Y, 20, 24, 26, 27, 2E, 2H, 36, 60, 64, 66, 67, 6A, 6C, 6E, 6G, 6H, 6J, 6N, 6P, 6V, 6W, 6X, 6Y**, L6**	

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusions apply to all the above:

A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.

B. Individuals who have commercial HMO coverage. Individuals with Medicare FFS coverage are not excluded from enrolling under this Contract.

Qualified Autism Services (QAS) Provider means a licensed practitioner or Board Certified Behavior Analyst (BCBA).

QAS Professional means 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.

QAS Paraprofessional means an individual who is employed and supervised by a QAS Provider to provide Medically Necessary BHT services to Members.

Significant Change means changes in Covered Services, benefits, the geographic Service Area, composition of payments to its Network, or enrollment of a new population, as stated in APL 18-XXX.

XXII. Exhibit E, Attachment 1, PROGRAM TERMS AND CONDITIONS, is amended to read:

Commented [ACR(5]: Adding for the plan contracts expiring within SFY 18/19 only.

11. Term

A. The Contract will become effective [redacted] and will continue in full force and effect through [redacted] **June 30, 2019** subject to the provisions of Exhibit B, Provision 1. Budget Contingency Clause, the Centers for Medicare and Medicaid Services waiver approval, and Exhibit D(F), Provision 3. Federal Contract Funds.

XXIII. All rights, duties, obligations and liabilities of the parties hereto otherwise remain unchanged.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Ratifying a Revised Amendment to Agreement 16-93274 with the California Department of Health Care Services in Order to Continue Operation of the OneCare Program

Contact

Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Action

Ratify Revised Amendment 04 to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS), in order to continue operation of the OneCare program.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into new five-year Primary and Secondary Agreements with DHCS that have been subsequently extended and amended. Amendments to these agreements are summarized in the attached appendix. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman of CalOptima's Board of Directors executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman of CalOptima's Board of Directors has executed four amendments to the agreement to extend the contract termination date, pursuant to Board authority, most recently during the June 2020 meeting of the Board.

Discussion

Amendment to Agreement 16-93274

In June 2020, Staff received authority from the CalOptima Board of Directors to execute an amendment to Agreement 16-93274 in order to extend the term of the contract and to add language required by the Centers for Medicare and Medicaid Services (CMS). As Staff had not received the language of the amendment from DHCS in time to bring it to the June 2020 Board of Directors Meeting, a more general authority was pursued with a commitment to return to the Board of Directors for an updated, specific authority as a matter of ratification. This approach was necessary in order for CalOptima to submit evidence of a MIPPA-compliant Medicaid contract for the 2021 contract year no later than July 6, 2020. As expected, in June DHCS provided CalOptima with an amendment to extend Agreement 16-93274 for an additional year, through December 31, 2021. Staff procured the Chair's signature of the amendment pursuant to the authority granted to the Chair during the June 2020 meeting of the CalOptima Board of

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Directors and have since received the countersigned copy of the amendment from DHCS. Staff has successfully submitted to CMS its MIPPA filing that was predicated on the contract extension.

As expected, the amendment contains language changes in addition to the extension of the expiration date in order to meet the requirements contained within the October 7, 2019 CMS memorandum "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)". The changes contained within Amendment 04 (A-04) of Agreement 16-93274 are outlined in the following grid:

5.11 D-SNP State Medicaid Agency Contract Requirements:

SMAC Contract Provision Requirements
1. How the SNP coordinates the delivery of Medicaid benefits for individuals who are eligible for such services
2. How the SNP provides coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services
3. The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP
4. Medicaid benefits covered under a capitated contract between the State Medicaid Agency and the MA organization offering the SNP • Medicaid behavioral health services, • Medicaid long-term supports and services, • Medicaid payment of Medicare cost sharing, and • Other Medicaid benefits
5. Language that identifies the entity that holds the capitated contract with the State Medicaid Agency for the Medicaid benefits covered
6. Cost-sharing protections covered under the SNP
7. Identification and sharing of information on Medicaid provider participation
8. Verification of enrollee's eligibility for both Medicare and Medicaid
9. Service area covered by the SNP
10. Contract period for the SNP (Extension of termination date to 12/31/2021)
11. Language regarding the full-benefit dual eligible individuals for which notification of hospital and skilled nursing facility admissions to the State Medicaid Agency will apply.

Changes contained within the D-SNP DHCS contract:

Category	Type of Update	Update
General Change	Clarification Language	Added D-SNP before Contractor throughout contract.
General Change	Clarification Language	Replaced Denti-Cal with Medi-Cal Dental throughout contract.
Exhibit A, Attachment 1 Coordination of Care	Clarification Language	Care Coordination (Section 1) D-SNP Contractor responsibilities for coordinating the delivery of all benefits.

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		C) D-SNP Contractor is not responsible for the provision of, or paying reimbursement for, any Medi-Cal benefits**.** Member Billing Prohibitions (Section 5) D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted. Provider Network Reporting Requirements (Section 6) D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted.
Exhibit A, Attachment 1 Coordination of Care	New Requirement	Added Sections D and E Outlines the new monthly and semi-annual Information Sharing reporting requirements. Specifically, it describes the process for sharing information on hospital and skilled nursing facility (SNF) admissions with DHCS for all dual eligible members enrolled in the D-SNP, starting January 1, 2021. D) The monthly report will contain all Dual Eligible Member admissions to a hospital or Skilled Nursing Facility (SNF) for any reason. E) D-SNP Contractor will provide a summary report via SFTP to DHCS on a semi-annually basis.
Exhibit E, Attachment 2 Program Terms and Conditions	Clarification Language	Discrimination Prohibition (Section 26) D-SNP Contractor shall not unlawfully discriminate against Members or beneficiaries eligible for enrollment into Contractor's D-SNP on the basis because of sex, race, color, creed, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups.

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		Federal and State Nondiscrimination Requirements (Section 27) Contractor shall comply with all applicable federal and California nondiscrimination requirements.
Exhibit E, Attachment 2 Program Terms and Conditions	New Requirement	D-SNP Contractor shall process a grievance for discrimination as required by federal and state law (Section 28) D-SNP Contractor shall designate a discrimination grievance coordinator responsible for ensuring compliance with federal and State nondiscrimination requirements and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or State nondiscrimination law. C) Within ten calendar days of mailing a discrimination grievance resolution letter, D-SNP Contractor shall submit the following information regarding the discrimination grievance in a secure format to the DHCS Office of Civil Rights.
Exhibit G, Business Associate Agreement (BAA)	Replaced	Exhibit G, Attachment A, Health Insurance Portability and Accountability Act (HIPAA) of the contract has been replaced by Exhibit G, Business Associate Addendum. Notable updates include the revisions to the Information Security controls (formerly Attachment A) and the removal of the 72-hour reporting requirement for privacy and security incidents.

To ensure timely submission to the DHCS, the outgoing Board Chair has executed the amendment. Accordingly, Staff requests and recommends that the CalOptima Board of Directors provide an updated authority to execute this contract amendment at this time, as a matter of ratification.

Fiscal Impact

The recommended action to ratify Amendment 04 to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral.

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Rationale for Recommendation

CalOptima's execution of Amendment 04 (A-04) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare program during 2021.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Appendix summary of amendments to Agreements with DHCS
2. CMS Memorandum "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)"
3. CalOptima Contract Amendment 16-93274 A04
4. Exhibit G_Business Associate Addendum
5. Exhibit H_Medi-Cal Benefits and Covered Services
6. June 4, 2020 CalOptima Board Action Agenda Referral "Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to Agreement 16-93274 with the California Department of Health Care Services (DHCS) in Order to Continue Operation of the OneCare and OneCare Connect Programs"

/s/ Richard Sanchez — *07/29/2020*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 4

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

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

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Amendments to Primary Agreement	Board Approval
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014

Amendments to Primary Agreement	Board Approval
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-45 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013

A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019
A–04 extends the Agreement 16–93274 with DHCS to December 31, 2021	June 4, 2020

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: October 7, 2019

TO: Dual Eligible Special Needs Plans

FROM: Sharon Donovan

Director, Program Alignment Group

SUBJECT: CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)

The Bipartisan Budget Act (BBA) of 2018 permanently authorized Dual Eligible Special Needs Plans (D-SNPs), strengthened Medicare-Medicaid integration requirements, and directed the establishment of procedures to unify Medicare and Medicaid grievance and appeals procedures to the extent feasible for D-SNPs beginning in 2021. On April 16, 2019, CMS finalized rules (hereafter referred to as the April 2019 final rule) to implement these new statutory provisions.[1] This memorandum summarizes the new requirements and provides guidance to D-SNPs on the contract and operational changes needed for each type of D-SNP beginning for Contract Year (CY) 2021.

Summary of New D-SNP Requirements

We summarize the D-SNP requirements CMS codified in the April 2019 final rule below.

Integration Requirements

Starting in CY 2021, D-SNPs must meet the new Medicare-Medicaid integration criteria in at least one of the following ways:

- By meeting the requirements to be designated as a fully integrated Dual Eligible SNP (FIDE SNP), as defined at 42 CFR 422.2. A FIDE SNP is offered by the legal entity that also has a state contract as a Medicaid managed care organization (MCO) to provide Medicaid benefits, including long-term services and supports (LTSS) and behavioral health benefits, consistent with state policy; or

- By meeting the requirements to be designated as a highly integrated D-SNP (HIDE SNP), as defined at 42 CFR 422.2. A HIDE SNP covers Medicaid LTSS and/or Medicaid behavioral health benefits, consistent with state policy, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or

- By having a contract with the state specifying a process to share information with the state, or the state's designee (such as a Medicaid MCO or an area agency on aging), on

[1] See CMS-4185-F, the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule. Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

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hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk individuals who are enrolled in the D-SNP, as provided at 42 CFR 422.107(d).

Unified Appeals and Grievances Processes

Certain D-SNPs and affiliated Medicaid managed care plans – specifically, those with "exclusively aligned enrollment" as described in more detail in the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this memorandum – must implement unified Medicare and Medicaid grievance and plan-level appeals processes starting in CY 2021. For these plans and their enrollees, implementation of the April 2019 final rule requirements will provide simpler, more straightforward grievance and appeals processes.

State Medicaid Agency Contract and Operational Changes

All D-SNPs must have executed contracts with applicable state Medicaid agencies, referred to as the "State Medicaid Agency Contract" (SMAC), as provided under section 1859(f)(3)(D) of the Social Security Act and 42 CFR 422.107. This section of the memorandum describes the SMAC and operational changes D-SNPs must implement to operate in CY 2021 and beyond. The first subsection describes requirements that apply to all D-SNPs. Subsequent subsections describe requirements that apply only to certain subsets of D-SNPs.

Requirements for all D-SNPs

D-SNPs are required to submit by the first Monday in July a SMAC to CMS for each state in which they seek to operate for the upcoming contract year. CY 2021 contracts must be submitted to CMS by July 6, 2020. Unlike in prior years, for CY 2021, D-SNPs with an evergreen SMAC will not be able to only submit letters of good standing with a previously executed SMAC from their respective states.

The April 2019 final rule modified several existing SMAC requirements that apply to all D-SNPs and added new requirements for some D-SNPs. To comply with these requirements for CY 2021, D-SNPs will need to work with state Medicaid agencies in advance of July 2020. (See the "Key Dates for D-SNPs" section of this memorandum for more information.) The table below highlights these changes to the minimum state contract elements.

The SMAC must document:
1. ***Revised:*** The D-SNP's: (1) responsibility to coordinate the delivery of Medicaid benefits; and (2) if applicable, responsibility to provide coverage of Medicaid services.
2. ***Revised:*** The category(ies) and criteria for eligibility for dually eligible individuals to be enrolled under the D-SNP (e.g., conditions of eligibility under Medicaid, such as nursing home level of care and age or requirement for D–SNP enrollees to enroll in a companion Medicaid plan to receive their Medicaid services).
3. ***Revised:*** The Medicaid benefits covered under a capitated contract between the state Medicaid agency and the MA organization offering the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.
4. The cost-sharing protections covered under the D-SNP.
5. The identification and sharing of information on Medicaid provider participation.
6. The verification of enrollees' eligibility for both Medicare and Medicaid.
7. The service area covered by the D-SNP.

The SMAC must document:
8. The contract period for the D-SNP.
9. ***New:*** For a D-SNP that is not a FIDE SNP or HIDE SNP, a requirement for notification of hospital or SNF admissions for at least one designated group of "high risk" enrollees (see the "Information Sharing Requirements for all D-SNPs except FIDE SNPs and HIDE SNPs" section of this memorandum for more information).
10. ***New:*** For a D-SNP that is an applicable integrated plan, a requirement for the use of the unified appeals and grievance procedures (see the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this memorandum for more information).

In addition to the above contract requirements, 42 CFR 422.562(a)(5), codified in the April 2019 final rule and effective beginning 2020, requires that all D-SNPs assist their enrollees with Medicaid-related grievances and address access to care issues (such as filing appeals) as part of D-SNPs' responsibility to coordinate the delivery of Medicaid benefits in 42 CFR 422.2.

Information Sharing Requirements for All D-SNPs except FIDE SNPs and HIDE SNPs

As provided under 42 CFR 422.107(d), D-SNPs that do not contract with a state as FIDE SNPs or HIDE SNPs must include the additional minimum SMAC requirement to specify a process to share information on hospital and SNF admissions starting for CY 2021. For the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SMAC must describe:

- The process whereby the D-SNP notifies, or arranges for another entity or entities to notify, the state (and/or the state's designee) of hospital and SNF admissions for at least one group of high-risk full-benefit dually eligible individuals, identified by the state;
- The timeframe and methods by which such notice is provided; and
- The group(s) of high-risk full-benefit dually eligible individuals for whom the notice is provided.

The April 2019 final rule provides flexibility to the state on the parameters of the notification process, including:

- The manner in which notification occurs and how data is exchanged;
- The recipient(s) of the notification; and
- The group of high-risk full-benefit dually eligible individuals to which the notification applies, with no requirement on minimum size.

A state and a D-SNP may arrange for other entities to perform their respective obligations with respect to the notification. A state could contract with a D-SNP such that the D-SNP meets the notification requirement by arranging for another entity – such as a hospital – to notify the state or its designees when the various parties participate in a health information exchange (HIE) or other notification system

We encourage D-SNPs to engage with states and stakeholders as soon as possible to identify the most effective approaches and processes for this notification requirement. We note some existing resources for technical assistance and best practices at the end of this memorandum.

Requirements for All FIDE SNPs and HIDE SNPs

Beginning with CY2021, CMS is establishing a new procedure for identifying a D-SNP as a FIDE SNP or HIDE SNP when fully executed SMACs are submitted to CMS on the first Monday of July 2020. MA organizations seeking to offer FIDE SNPs and HIDE SNPs must request a CMS review of the SMAC so that CMS can confirm it complies with the contract requirements for FIDE SNPs and HIDE SNPs.

Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment

A subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment must implement the unified appeals and grievance procedures described in 42 CFR 422.629 – 634 beginning in 2021. In the regulations, we refer to these plans as "applicable integrated plans," defined at 42 CFR 422.561 as FIDE SNPs or HIDE SNPs with exclusively aligned enrollment, where state policy limits the D-SNP's membership to a Medicaid managed care plan offered by the same organization. (In addition, the Medicaid MCO that covers Medicaid benefits for the dually eligible individuals in the FIDE SNP or HIDE SNP with exclusively aligned enrollment is also an applicable integrated plan subect to the unified appeals and grievance procedures under 42 CFR 438.210 and 438.402.) In such plans, one organization is responsible for managing Medicare and Medicaid benefits for all D-SNP enrollees.

SMACs for these plans must include provisions that the D-SNP uses the unified appeals and grievance procedures under 42 CFR 422.629 through 422.634, as well as conforming Medicaid managed care rules at 438.210, 438.400, and 438.402. The unified appeals process includes use of a specialized integrated denial notice (*see* 42 CFR 422.631(d)) for applicable integrated plans. CMS is developing a model of this and other appeals and grievance notices and will provide opportunities for comment before finalizing them.

As specified in the April 2019 final rule, states have the discretion to implement standards different than those established in the final rule if the state standards are more protective for enrollees, such as shorter timelines for a plan to make a decision on an appeal (*see* 42 CFR 422.629(c)). The SMAC must specify any requirements where the states use this discretion to implement standards different than those in 42 CFR 422.629 through 422.634, and D-SNPs must comply with any state-specific requirements in the SMAC. States may also need to make changes to Medicaid MCO contracts for the applicable integrated plans to specify the additional requirements for unified grievances and appeals from 42 CFR 422.629 through 422.634, 438.210, 438.400, and 438.402.

Intermediate Sanctions

As provided in 42 CFR 422.752, for any D-SNP not meeting the integration criteria listed in this memorandum and specified at 42 CFR 422.2, CMS will impose, during plan years 2021 through 2025, intermediate sanctions specified at 42 CFR 422.750(a). CMS will impose intermediate sanctions specifically where CMS determines that a D-SNP fails to meet at least one of the criteria for the integration of Medicare and Medicaid benefits provided in the definition of a D-SNP at 42 CFR 422.2 and specified above.

Key Dates for D-SNPs

All D-SNPs are required to submit a new SMAC (or an evergreen SMAC with a contract addendum) to CMS for each state in which they seek to operate in for CY 2021 by Monday July 6, 2020. This includes, as applicable, the new contract requirements codified in 42 CFR 422.107(c) and (d) and summarized in this memorandum. **Therefore, we strongly encourage**

states and D-SNPs to begin discussing SMAC updates as soon as possible. The table below provides key dates and activities for states and D-SNPs related to compliance with the new requirements.

Month/Year	Activity
Fall 2019	• States and D-SNPs begin drafting changes needed to ensure SMAC meets new requirement • States plan for any needed MCO contract changes
Winter 2020	• States and D-SNPs identify and create any new policies and procedures needed in response to contract changes
January 2020	• CMS releases Contract Year 2021 MA (SNP) applications
February 2020	• SNP applications (including SNP service area expansion applications) due to CMS
Spring 2020	• States and D-SNPs finalize SMACs
June 2020	• D-SNPs not renewing MA contracts notify CMS in writing • Bid submission deadline
July 2020	• D-SNPs submit SMAC and related documents to CMS by Monday July 6, 2020
July/August 2020	• D-SNPs work with CMS and states to address deficiencies in SMACs
Summer 2020 - Fall 2020	• States and D-SNPs finalize policies and procedures for CY 2021
August/September 2020	• CMS issues SMAC status review letters and, as applicable, intermediate sanction letters • D-SNPs send Annual Notice of Change and Evidence of Coverage (including information about any changes to grievances and appeals procedures for applicable integrated plans) to current enrollees
January 1, 2021	• Effective date for most April 2019 final rule provisions

Resources

The CMS Medicare-Medicaid Coordination Office (MMCO) works across CMS and with states to better serve dually eligible individuals, including through efforts to better align the Medicare and Medicaid programs through integrated service delivery under D-SNPs. We are providing technical assistance to states to help with implementation of these new requirements through the Integrated Care Resource Center (ICRC). We believe the information for states will also be helpful to D-SNPs as they update SMACs to meet the requirements detailed in this memorandum.

Listed below are currently available resources.

- **Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021** (https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-

snps-basics-and-meeting-new-federal-requirements-2021) provides an overview of state strategies for contracting with D-SNPs to improve care coordination and Medicare-Medicaid alignment for dually eligible enrollees. Special attention is given to new federal D-SNP integration standards for 2021 contract year, and how states can help plans to meet these requirements.

- **Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations** (https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions) examines the approaches used by three states to develop and implement information-sharing processes for their D-SNPs that support care transitions. The brief includes examples of contract language and strategies to encourage plan collaboration and problem solving around information sharing. It can help states, D-SNPs, and other stakeholders assess how to meet the new D-SNP contracting requirements and improve the care of dually eligible individuals.

- **Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plans Enrollees: Key Questions for State Implementation** https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan) offers key questions and considerations that states can review as they begin working with D-SNPs and other parties to design and implement information-sharing requirements. This technical assistance tool includes sample contract language.

Additionally, we expect ICRC to develop and disseminate sample contract language that both state and D-SNPs can use to develop their SMACs.

More Information

For any questions about the contents of this memorandum, D-SNPs should contact their account manager.

Exhibit A
SCOPE OF WORK

1. Service Overview

This contract is being executed with this Contractor that is a Dual Eligible Special Needs Plan (D-SNP) that is also a Cal Medi-Connect (CMC) ~~and does not have an existing subcontract with a Medi-Cal managed care plan in the Service Area(s) included in this contract to satisfy the requirements listed in 42 Code of Federal Regulations (CFR) 422.107~~.

Contractor agrees to provide to the Department of Health Care Services (DHCS) the services described herein:

Care coordination of the Medi-Cal benefits and services provided to eligible Medi-Cal beneficiaries **but** ~~and~~ which are not covered by the Medicare Advantage health plan under whose authority the CMC D-SNP Contractor operates. These Medi-Cal benefits and services are defined in the contents of this D-SNP Contract.

2. Project Representatives

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

Department of Health Care Services	**Orange County Organized Health**
Managed Care Operations Division (MCOD) Attn: Chief, Managed Care Systems and Support Services Branch	dba: CalOPTIMA Attn: Michael Schrader, Chief Chief Executive Officer E-mail: schrader@caloptima.org
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: (714) 246-8458

B. Direct all inquiries to:

Department of Health Care Services	**Orange County Organized Health**
Managed Care Operations Division Attn: Contracting Officer	dba CalOPTIMA Attn: Michael Schrader, Chief Officer
MS 4408 P.O. Box 997413 Sacramento, CA 95899-7413	505 City Parkway West Orange, CA 92868
Telephone: (916) 449-5000 Fax: (916) 449-5090	Telephone: (714) 246-8458

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Exhibit A
SCOPE OF WORK

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

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

Exhibit A, Attachment 1
COORDINATION OF CARE

1. Care Coordination

This D-SNP Contract is a care coordination agreement. **D-SNP Contractor is responsible for coordinating the delivery of all benefits covered by both Medicare and Medi-Cal, including when Medi-Cal benefits are delivered via Medi-Cal Fee-For-Service (FFS), managed care, or other Medi-Cal delivery systems. D-SNP Contractor is responsible for coordinating the Member's Medicare and Medi-Cal benefits including, but not limited to, discharge planning, disease management, and care management.** ~~The Medi-Cal benefits that Contractor must coordinate include all Medi-Cal benefits and services that are not covered by the Medicare Advantage health plan under whose authority the CMC D-SNP operates.~~ **D-SNP** Contractor shall:

A. Contractor shall develop and implement care coordination procedures that are submitted to and approved by DHCS for referral and coordination of care for Members who receive benefits and services through **either** the Medi-Cal managed care or ~~Fee-For-Service (~~FFS~~)~~ program. Medi-Cal benefits and services requiring referral and coordination of care by **D-SNP** Contractor are outlined in Exhibit H.

1) For Medi-Cal managed care Members, Contractor's D-SNP will contact the Member's Medi-Cal managed care plan for provider information and for the coordination of Medi-Cal managed care covered benefits. Managed care health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx;

2) For Medi-Cal FFS Members, Contractor's D-SNP will contact Medi-Cal for provider information and the coordination of Medi-Cal FFS benefits. Medi-Cal contact information can be found at the following link: http://www.medi-cal.ca.gov/contact.asp;

3) For coordination of behavioral health services, Contractor's D-SNP will contact the Member's Medi-Cal managed care health plan and/or the county mental health plans for provider information and the coordination of behavioral health services. County mental health plan contact information can be found at the following link: http://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx;

~~4)~~ For coordination of In-Home Supportive Services **(IHSS)** benefits, Contractor's D-SNP will contact the **County IHSS Office. County IHSS Office contact information can be found at https://www.cdss.ca.gov/inforesources/county-ihss-offices** ~~California Department of Social Services (CDSS). CDSS contact information can be found at the following link:~~

~~http://www.cdss.ca.gov/agedblinddisabled/PG1785.htm~~; and

5) For coordination of ~~Denti-Cal~~**Medi-Cal Dental** benefits, Contractor's D-SNP will contact ~~Denti-Cal~~ **the DHCS Dental Administrative Service Organization (ASO)** for provider information and the coordination of dental benefits. ~~Denti-Cal~~**ASO** contact information can be found at the following link: http://www.denti-cal.ca.gov/WSI/contact.jsp?fname=ContactInfo.

B. When a Member requests or **D-SNP** Contractor determines a Member may need a Medi-Cal benefit or service that is not covered by the D-SNP, Contractor shall make a referral to DHCS for follow-up and possible provision of those benefits or services

C. D-SNP Contractor is not responsible for the provision of, or paying reimbursement for, any Medi-Cal benefits. D-SNP Contractor shall maintain a current knowledge and familiarity of Medi-Cal benefits through ongoing reviews of California laws, rules, policies, and further guidance as posted on the California Department of Health Care Services (DHCS) website. D-SNP Contractor shall timely coordinate Medi-Cal benefits and services requiring referral and coordination of care as outlined in Exhibit H for its Enrolled Dual Eligible Members under this Contract.

This Provision details D-SNP Contractor's specific Medicare-Medi-Cal care coordination requirements. Medi-Cal Covered Services are described in Title XIX of the Social Security Act, 42 CFR sections 440 and 441, the California Medicaid State Plan, Section 3.2, Provision 1 of this Attachment, the DHCS and Medi-Cal websites, and other relevant materials.

D. D-SNP Contractor will provide a report via SFTP in Excel format to DHCS on a monthly basis by the close of business on the sixth business day after the end of the reporting month. The report will contain all Dual Eligible Member admissions to a hospital or Skilled Nursing Facility (SNF) for any reason. Reports will include:

1) Beneficiary Demographic Information

a) First Name, Last Name

b) Medicare Beneficiary Identifier (MBI)

c) Date of Birth

d) Client Index Number (CIN) – if available

2) Inpatient Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, case worker – if available)

3) Skilled Nursing Facility (SNF) Admissions

a) Date of Notification

b) Date of Admission

c) Admitting Facility – if available

d) Admitting Cause/Diagnosis – if available

e) Type of Admission (e.g., emergency versus directed)

f) Care Manager (provider, social worker, case worker – if available)

4) Discharge Planning Documents (if available)

a) Discharge date and time

b) Discharge disposition

c) Discharging Facility

d) Discharge diagnosis

e) Discharge instructions

E. D-SNP Contractor will provide a summary report via SFTP to DHCS on a semi-annually basis, due July 31 and January 31 for the previous six-month period, to DHCS for Dual Eligible Members hospitalized or in a skilled nursing facility. D-SNP Contractor's report shall include the following:

1) Number and percentage of population hospitalized;

2) Percentage of population having care coordination prior to hospitalization;

3) Number and percentage of populations offered care coordination following hospitalization;

4) Number and percentage of population accepting care coordination;

5) Number and percentage of populations readmitted from the prior year;

6) Average length of stay;

7) Number discharged from hospital to community;

8) Number discharged from hospital to SNF;

9) Number discharged from hospital to other Facility:

10) Number discharged from SNF to community;

11) Number discharged from SNF to other Facility:

In the event that D-SNP Contractor authorizes another entity or entities to perform this notification, D-SNP Contractor must retain responsibility for complying with this requirement.

2. All Plan and Policy Letters

In addition to the terms and conditions of this Contract. **D-SNP** Contractor shall comply with All Plan Letters (APLs) and Policy Letters (PLs), including but not limited to APL 12-001 and 13-003, as well as any

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subsequent updates, which are incorporated by reference into this Contract.

3. Coverage Area and Eligible Beneficiaries

Members covered under this Contract shall include all Dual Eligible Members who are enrolled in the CMC D-SNP. Contractor may enroll the following populations:

A. Dual Eligible Medi-Cal beneficiaries who reside in the following Coordinated Care Initiative (CCI) Demonstration project county or counties to maximize the continuum of services available through both Medicare and Medi-Cal:

Orange County

B. Dual eligible Medi-Cal beneficiaries who are excluded from enrollment into Cal MediConnect as follows:

1) Individuals under the age of 21;

2) Individuals with other private or public health insurance;

3) Developmentally Disabled (DD) beneficiaries receiving services through a Department of Developmental Services 1915(c) waiver, regional center, or state developmental center;

4) Individuals with a share of cost - in community and not continuously certified;

5) Individuals residing in one of the Veterans' Homes of California;

6) Individuals residing in an excluded zip code per the Memorandum of Understanding (MOU) between the State and the Centers for Medicare and Medicaid Services (CMS); Beneficiaries in the following 1915(c) waiver:

7) Beneficiaries in the following 1915(c) waiver:

a) Nursing Facility/Acute Hospital Waiver;
b) HIV/AIDS Waiver;
c) Assisted Living Waiver; and
d) In Home Operations Waiver.

8) Intermediate Care Facility - DD Residents.

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C. Individuals who are passively enrolled into Cal MediConnect and subsequently opt-out of Cal MediConnect shall not be eligible to re-enroll in the CMC D-SNP.

4. Certification and Enrollment Reporting

D-SNP Contractor shall comply with APL 12-001 and 13-003, as well as any subsequent updates, and shall submit to DHCS:

A. A certification, signed by the Chief Operations Officer or similar D-SNP executive officer, that attests to the number of Members enrolled in the D-SNP as of January 1, 2017.

B. A report by the fifth working day of each month during the term of this Contract, signed by the Chief Operations Officer or similar D-SNP executive officer, summarizing the previous month's ~~enrollment~~**Enrollment** numbers.

5. Member Billing Prohibitions

~~A. Contractor shall not bill a Member for any services provided under this Contract.~~

~~B. Contractor shall ensure that the Member shall be held harmless for charges for any Medi-Cal covered benefit or service.~~

~~C. Pursuant to Section 1932(b)(6) of the Social Security Act, (42, USC, Section 1396u-2 (b)(6)), Contractor shall not hold a D-SNP Member liable for Contractor's debts in the event of insolvency.~~

~~D. Contractor is subject to imposition of sanctions as authorized by Title 42 CFR 422.6 if it imposes premiums or charges not permitted on Members under the Medi-Cal program.~~

A. D-SNP Contractor and its contracted providers are prohibited from imposing cost-sharing requirements on Dual Eligible Members that would exceed the amounts permitted under the California Medicaid State Plan, Section 1852(a)(7) of the Act, and 42 CFR section 422.504(g)(1)(iii). D-SNP Contractor shall not bill a Dual Eligible Member with QMB benefits for Medicare cost sharing amounts, including deductibles, coinsurance, and copayments, in accordance with Section 1902(n)(3)(B) of the Social Security Act.

B. A Dual Eligible Member with QMB benefits has no legal obligation to make further payment to a provider or to D-SNP Contractor for Medicare Part A or Part B cost sharing amounts. D-SNP Contractor's provider agreements shall specify that a contracted Medicare provider agrees to accept D-SNP Contractor's Medicare reimbursement as payments in full for services rendered to Dual Eligible Members, or to bill Medi-Cal or the Member's Medi-Cal managed care plan as applicable for any additional Medicare payments that may be reimbursed by Medi-Cal.

6. Provider Network Reporting Requirements

Upon execution of this Contract, Contractor shall submit to DHCS an initial report that outlines DHCS's full Medi-Cal provider network within the defined service area.

A. D-SNP contractor can obtain Medi-Cal participating providers by reviewing the California Health and Human Services Open Data Portal. The California Health and Human Services Open Data Portal can be found at: https://data.chhs.ca.gov/dataset/profile-of-enrolled-medi-cal-fee-for-service-ffs-providers. Any D-SNPs affiliated with a companion Medi-Cal managed care plan can obtain the file from the affiliated Medi-Cal plan.

B. Contractor will identify in its provider directory those providers that accept both Medicare and Medicaid (providers that are currently registered providers under Medi-Cal and are also within D-SNP Contractor's network).

~~A~~**C.** The report, at a minimum, shall include the following:

1) NPI (National Provider Identifier);

2) First and last name;

3) Specialty type;

4) Group association;

5) Full address;

6) Telephone number;

7) Cultural and linguistic services, including provider and provider staff language capability;

8) Hospital admitting privileges; and

9) Provider capacity, including current capacity.

~~B~~**D.** After the initial submission of a Medi-Cal provider network report, **D-SNP** Contractor shall submit an updated report at least:

1) Quarterly; and

2) Whenever a significant change to the network affects provider capacity and services, including changes in:

a) Services or benefits;

b) Geographic Service Area or payments; or

c) Enrollment of a new population.

~~C~~**E.** The quarterly report shall include, at a minimum, the following:

1) Network provider deletions: The number of Members assigned to each primary care physician that has been deleted from the network.

2) Network providers who are not accepting new patients; and

3) Provider additions: Each provider addition must include the information prescribed in the initial Medi-Cal provider network report.

7. Medi-Cal and Medicare Eligibility Verification

A. It is **D-SNP** Contractor's responsibility to:

1) Confirm Medicare Advantage and Medi-Cal eligibility;

2) Verify Medi-Cal eligibility of a Member, Medi-Cal agrees to provide D-SNP Contractor with real-time acess to the Medi-Cal's eligibility verification system;

~~2)~~**3)** Confirm all applicable Medicare Advantage special needs criteria are met, based on D-SNP type.

~~B. Contractor shall ensure that only eligible beneficiaries as defined in Exhibit A, Attachment 1, Provision 3, receive services under this Contract.~~ Contractor ~~shall verify~~**must validate Medicare Advantage and** Med-Cal ~~and Medicare~~

eligibility through its existing on-line and/or batch Medicare and Medi-Cal eligibility user interfaces ~~prior to a dual eligible beneficiaries receiving care coordination~~.

8. Contract Term

This D-SNP Contract shall be effective from January 1, 2017 through ~~December 31, 2020~~**December 31, 2021**

9. Termination

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

10. Compensation

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

11. Centers for Medicare and Medicaid Services Documentation

Contractor shall submit to DHCS a complete and accurate copy of the bid submitted to CMS.

GTC 307 **Exhibit C**

GENERAL TERMS AND CONDITIONS

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

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

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

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

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

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

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

7. TERMINATION FOR CAUSE: The State may terminate this Agreement and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination the State may proceed with the work in any manner deemed proper by the State. All costs to the State shall be deducted from any sum due the Contractor under this Agreement and the balance, if any, shall be paid to the Contractor upon demand.

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

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

10. NON-DISCRIMINATION CLAUSE: During the performance of this Agreement, Contractor shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Contractor shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. D-SNP Contractor shall comply with the provisions of the Fair Employment and Housing Act (Government Code Section 12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (Title 2 CCR Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Title 2 CCR Chapter 5 of Division 4, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

GTC 307 **Exhibit C**
GENERAL TERMS AND CONDITIONS

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

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

13. COMPENSATION:

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

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

15. ANTITRUST CLAIMS:

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

16. CHILD SUPPORT COMPLIANCE ACT:

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

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

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

Exhibit D(F)
SPECIAL TERMS AND CONDITIONS

1. Federal Equal Opportunity Requirements

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

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

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

D. Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 USC 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance

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Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

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

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

G . Contractor will include the Provisions of Paragraphs A through G in every purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 USC 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each vendor. Contractor will take such action with respect to any purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event Contractor becomes involved in, or is threatened with litigation by a vendor as a result of such direction by DHCS, the D-SNP Contractor may request in writing to DHCS, who, in turn, may request the

United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

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

3. Procurement Rules

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

4. Equipment Ownership / Inventory / Disposition

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

5. Subcontract Requirements

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

6. Income Restrictions

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

7. Audit and Record Retention

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

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder and the premises in which it is being performed. If any inspection or evaluation is made of the premises of Contractor, Contractor shall provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

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

B. This D-SNP Contract is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this D-SNP Contract. In addition, this D-SNP Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress that may affect the provisions, terms or funding of this D-SNP Contract in any manner.

C. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this D-SNP Contract shall be amended to reflect any reduction in funds.

D. DHCS has the option to invalidate or cancel the D-SNP Contract with 30-days advance written notice or to amend the D-SNP Contract to reflect any reduction in funds.

10. Intellectual Property Rights

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

11. Air or Water Pollution Requirements

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

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

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

12. Prior Approval of Training Seminars, Workshops or Conferences

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

13. Confidentiality of Information

A. Contractor and its employees, agents shall protect from unauthorized disclosure names and other identifying information concerning persons either

receiving services pursuant to this D-SNP Contract or persons whose names or identifying information become available or are disclosed to Contractor, its employees or agents as a result of services performed under this D-SNP Contract, except for statistical information not identifying any such person.

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

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

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

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

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

14. Documents, Publications and Written Reports

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

15. Dispute Resolution Process

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

16. Financial and Compliance Audit Requirements

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

17. Human Subjects Use Requirements

By signing this D-SNP Contract, Contractor agrees that if any performance under this D-SNP Contract includes any tests or examination of materials derived from the human body for the purpose of providing information,

diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 USC 263a (CLIA) and the regulations thereto.

18. Novation Requirements

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

19. Debarment and Suspension Certification

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

B. By signing this D-SNP Contract, 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 D-SNP Contract have been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State or local) transaction or contract under a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

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

4) Have not within a three (3) year period preceding this D-SNP Contract had one or more public transactions (federal, State or local) terminated for cause or default.

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

6) Will include a clause entitled, "Debarment and Suspension Certification'' that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

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

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

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

20. Smoke-Free Workplace Certification

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

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

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

21. Covenant Against Contingent Fees

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

22. Payment Withholds

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

23. Performance Evaluation

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

24. Officials Not to Benefit

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

25. Four-Digit Date Compliance

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

26. Prohibited Use of State Funds for Software

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

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

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

28. Alien Ineligibility Certification

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

29. Union Organizing

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

30. Contract Uniformity (Fringe Benefit Allowability)

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

31. Lobbying Restrictions and Disclosure Certification

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

A. Certification and Disclosure Requirements

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

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

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

reported includes:

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

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

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

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

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

B. Prohibition

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

Exhibit, Attachment 1
DEFINITIONS

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

1. **Cal MediConnect Dual Eligible Special Needs Plan (CMC D-SNP)** means a Medicare Advantage Plan for beneficiaries who are dually eligible for Medicare and Medicaid that is also a Cal MediConnect plan.

2. **Care Coordination or Coordination of Care** means the identification of a medical condition that requires referral for Medi-Cal benefits or services that are not covered by the Medicare Advantage health plan under whose authority the D-SNP operates.

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

4. **Contract** means this written agreement between DHCS and Contractor.

5. **Coordinated Care Initiative (CCI)** means an initiative that includes a three-year Duals Demonstration project (Cal MediConnect) for beneficiaries who are dually eligible for Medicare and Medi-Cal (Duals) to combine the full continuum of acute, primary, institutional, and home and community-based services (HCBS) into a single benefit package, delivered through an organized service delivery system. CCI was enacted through SB 1008 (Chapter 33, Statutes of 2012), SB 1036 (Chapter 45, Statutes of 2012) and SB 94 (Chapter 34, Statutes of 2013), and includes a mandatory Medi-Cal managed care enrollment for Duals, and the inclusion of long-term services and supports (LTSS) as Medi-Cal managed care benefits for Seniors and Persons with Disabilities (SPD) beneficiaries who are eligible for Medi-Cal only, and for Dual SPD beneficiaries. CCI counties include Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara.

6. **Covered Service(s) or covered service(s)**, as used in this Contract, means care coordination or coordination of care. This is the only service covered under this Contract.

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

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Exhibit E, Attachment 1
DEFINITIONS

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

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

10. **Dual-Eligible Beneficiary** means an individual who is enrolled for benefits under Part A of Title 42 of the United States Code (commencing with Section 1395c) and Part B of Title 42 of the United States Code (commencing with Section 1395j) and is also eligible for medical assistance under the Medi-Cal State Plan.

11. **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of the D-SNP plan.

12.Facility means any premise that is:

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

B. Maintained by a Provider to provide services on behalf of Contractor.

~~12~~**13.** **Medi-Cal Managed Care Health Plan** means a managed care health plan that contracts with the Department of Health Care Services for provision or arrangement of Medi-Cal benefits and services.

~~13~~**14.** **Member** means any beneficiary who is enrolled in the Contractor's D-SNP.

~~14~~**15.** **Service Area** means the ~~county or counties that~~ **geographic area in which Members or potential Members reside and for whom** Contractor is approved to ~~operate in under the terms of this D-SNP Contract. A Service Area may have designated zip codes (under the U.S. Postal Service) within a county that are approved by DHCS to operate under the terms of this D-SNP Contract.~~ **provide services by CMS.**

~~15~~**16.** **State** means the State of California.

~~16~~**17.** **Working day(s)** mean State calendar (State Appointment Calendar, Standard101) working day(s).

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Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

1. Governing Law

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

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

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

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

C. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/ June 14, 2002, at 42 CFR, 400, 430, 431, 434, 435, 438, 440 and 447. **D-SNP** Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.

D. All existing final Policy Letters issued by MMCD or the current Managed Care Operations Division (MCOD) can be viewed at www.dhcs.ca.gov/formsandpubs/Pages/MMCDPlanPolicyLtrs.aspx and shall be complied with by **D-SNP** Contractor. All Policy Letters issued by MMCD subsequent to the effective date of this D-SNP Contract shall

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provide clarification of **D-SNP** Contractor's obligations pursuant to this D-SNP Contract, and may include instructions to **D-SNP** Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation. In the event DHCS determines that there is an inconsistency between this D-SNP Contract and a MMCD or MCOD Policy Letter or All Plan Letter, the D-SNP Contract shall prevail.

2. Entire Agreement

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

3. Amendment Process

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

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

4. Change Requirements

A. General Provisions

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

B. **D-SNP** Contractor's Obligation to Implement

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

5. Delegation of Authority

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

D-SNP Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of **D-SNP** Contractor, will make all determinations and take all actions as are appropriate to implement this D-SNP Contract, subject to the limitations of Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind **D-SNP** Contractor to all agreements reached with DHCS. **D-SNP** Contractor shall designate Contractor’s Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, Provision 14, Notices.

6. Authority of the State

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

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

7. Fulfillment of Obligations

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

8. Prohibition Against Assignments or Delegation of Contractor's Duties and Obligations Under this D-SNP Contract

D-SNP Contractor shall not negotiate or enter into any agreement to assign or delegate the duties and obligations under this D-SNP Contract. If **D-SNP** Contractor fails to comply with this Provision, DHCS may terminate the D-SNP Contract for cause in compliance with Exhibit E, Attachment 2, Provision 18.

9. Prohibition Against Subcontracts

This provision supersedes and replaces Provision 5 entitled, "Subcontract Requirements" in Special Terms and Conditions Exhibit D(F).
D-SNP Contractor shall not enter into subcontracts, regardless of the cost of services reimbursed under the D-SNP Contract, and DHCS shall not approve any subcontracts for the provision of care coordination services.

10. Prohibition Against Novations

This provision supersedes and replaces Provision 18 entitled, "Novation Requirements" in Special Terms and Conditions Exhibit D(F).
D-SNP Contractor and DHCS shall not enter any novation agreements. Contractor shall not propose any novation agreements nor shall DHCS agree to or act upon any proposal.

11. Obtaining DHCS Approval

D-SNP Contractor shall obtain written approval from as provided in Exhibit E, Attachment 3, Provision 5, DHCS Approval Process, prior to commencement of operation under this Contract.

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

12. Program

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

13. Certifications

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

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

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

Exhibit E, Attachment 2
PROGRAM TERMS AND CONDITIONS

14. Notices

All notices to be given under this D-SNP Contract will be in writing and will be deemed to have been given when mailed to DHCS or the D-SNP Contractor:

California Department of Health Care Services
Managed Care Operations Division
MS 4408
P.O. Box 997413
Sacramento, CA 95899-7413

Orange County Organized Health
System dba CalOptima
Attn: Michael Schrader, CEO
505 City Parkway West
Orange, CA 92868

15. Term

The D-SNP Contract will become effective January 1, 2017, and will continue in full force and effect through ~~December 31, 2020~~**December 31, 2021**

16. Service Area

The Service Area covered under this D-SNP Contract includes:
Orange County

All Contract provisions apply separately to each Service Area.

17. Contract Extension

DHCS ~~shall not~~ **may** extend this D-SNP Contract for any reason.

18. Termination for Cause and Other Terminations

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

A. Termination - State or Director

1) DHCS may terminate performance of work under this D-SNP Contract in whole, or in part, whenever for any reason DHCS determines that the termination is in the best interest of the State.

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2) Notification shall be given at **least** 60 days prior to the effective date of termination, except in cases described below in Paragraph B, Termination for Cause.

B. Termination for Cause

1) DHCS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22 CCR Section 53873.

2) DHCS shall terminate this Contract if Contractor either:

a) Fails to negotiate a subcontract in good faith with a Medi-Cal Managed Care Plan in the service area(s) in which the D-SNP operates;
b) Reaches a Contract negotiation impasse to enter into a subcontract with a Medi-Cal Managed Care Plan operating in its services area(s) and DHCS determines that is unlikely the Contractor and the Medi-Cal Managed Care Plan will reach an agreement.

3) DHCS shall submit a notice to terminate this Contract if Contractor fails to execute a subcontract with a Medi-Cal Managed Care Plan operating in Contractor's service area by January 1, 2017. The termination shall be effective ~~December 31, 2020~~**December 31, 2021**.

4) DHCS shall have the right to terminate this Contract if Contractor fails to demonstrate good faith negotiations for three (3) consecutive reporting periods pursuant to Exhibit A, Attachment 1, Provision 3.

5) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination. Except for termination pursuant to Paragraph B. 3) above, Contractor may dispute the termination decision through the dispute resolution process pursuant to Provision 18, Disputes. Termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the Department of Managed Health Care (DMHC) makes such determination, provided that DHCS provides Contractor with at least 60 calendar days' notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days' notice is reasonable.

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

C. Termination - D-SNP Contractor

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

D. Termination of Obligations

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

19. Disputes

In addition to Exhibit C, Provision 6, Disputes, **D-SNP** Contractor also agrees to the following:

This Disputes section will be used by **D-SNP** Contractor as the means of seeking resolution of disputes on contractual issues.

A. Disputes Resolution by Negotiation

DHCS and **D-SNP** Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

1) Within 15 calendar days of the date the dispute concerning performance of this D-SNP Contract arises or otherwise becomes known to **D-SNP** Contractor, **D-SNP** Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

2) **D-SNP** Contractor's notification will state, on the basis of the most

accurate information then available to **D-SNP** Contractor, the following:

a) That it is a dispute pursuant to this section.

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

c) The names, phone numbers, function, and activity of each **D-SNP** Contractor, DHCS/State official or employee involved in or knowledgeable about the conduct.

d) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

e) The reason **D-SNP** Contractor is disputing the conduct.

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

g) **D-SNP** Contractor's desired remedy.

3) The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by **D-SNP** Contractor. This documentation will serve as the basis for any subsequent appeal.

4) Following submission of the required notification, with supporting documentation, the D-SNP Contractor will comply with the requirements of Title 22, CCR, Section 53851(d) and diligently continue performance of this D-SNP Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by **D-SNP** Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by DHCS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this D-SNP Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the

alternate dispute officer shall either:

1. Find in favor of **D-SNP** Contractor, in which case the Contracting Officer or alternate dispute officer may countermand the earlier conduct which caused **D-SNP** Contractor to file a dispute; or

2. Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

3. Request additional substantiating documentation in the event the information in **D-SNP** Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise **D-SNP** Contractor as to what additional information is required, and establish how that information shall be furnished. **D-SNP** Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by **D-SNP** Contractor of all claims in accordance with Paragraph F, Waiver of Claims, below.

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

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

D-SNP Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with DHCS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include **D-SNP** Contractor's contentions as to those issues. However, **D-SNP** Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to Paragraph B, Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by **D-SNP** Contractor of all claims arising out of that conduct, in accordance with Paragraph F, Waiver of Claims below, **D-SNP** Contractor shall exhaust all procedures provided for in this Provision 19, Disputes, prior to initiating any other action to enforce this D-SNP Contract.

E) **D-SNP** Contractor Duty to Perform

Pending final determination of any dispute hereunder, **D-SNP** Contractor shall comply with the requirements of Title 22, CCR, Section 53851(d) and proceed diligently with the performance of this D-SNP Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision. If pursuant to an appeal under Paragraph D, Appeal of Contracting Officer's or Alternate Dispute Officer's Decision above, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to Paragraph D, shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and **D-SNP** Contractor shall promptly receive any benefits of such decision. DHCS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any appeal of such decision.

F. Waiver of Claims

If **D-SNP** Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this Provision 19, Disputes, that failure shall constitute a waiver by **D-SNP** Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

20. Audit

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

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

A. Books and Records

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

B. Records Retention

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

21. Inspection Rights

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

Through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, **D-SNP** Contractor shall allow the DHCS, DHHS, the Comptroller General of the United States, DOJ Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives, including DHCS' external quality review organization contractor, to **audit,** inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this D-SNP Contract, and to inspect, evaluate, and audit any and all **premises,** books, records, **equipment, contracts, computers or other electronic systems** and facilities maintained by **D-SNP** Contractor pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, and books of account, medical records, prescription files, laboratory results, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in Provision 20, Audit, Paragraph B, Records Retention above, **D-SNP** Contractor shall furnish any record, or copy of it, to DHCS or any other entity listed in this section, at **D-SNP** Contractor's sole expense.

A. Facility Inspections

DHCS shall conduct unannounced validation reviews on a number of **D-SNP** Contractor's primary care sites, selected at DHCS' discretion, to

verify compliance of these sites with DHCS requirements.

B. Access Requirements and State's Right to Monitor

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

To assure compliance with the D-SNP Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to **D-SNP** Contractor. This will include the Management Information System operations site or such other place where duties under the D-SNP Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and **D-SNP** Contractor will provide reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of **D-SNP** Contractor.

22. Confidentiality of Information

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

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

D-SNP Contractor may release medical records in accordance with applicable law pertaining to the release of this type of information. **D-SNP** Contractor is not required to report requests for Medical Records made in accordance with applicable law.

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

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

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

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

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

23. Third-Party Tort Liability

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

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

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

1) Member name.

2) Full 14-digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

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

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

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

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

E. Information submitted to DHCS under this section shall be sent to:

California Department of Health Care Services
Third Party Liability and Recovery Branch, Recovery Section
MS 4720
P.O. Box 997425
Sacramento, CA 95899-7425.

24. Records Related To Recovery for Litigation

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

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

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

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

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

25. Equal Opportunity Employer

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

26. Discrimination Prohibitions

A. Member Discrimination Prohibition

D-SNP Contractor shall not **unlawfully** discriminate against Members or beneficiaries eligible for enrollment into Contractor's D-SNP **on the basis** ~~because~~ of **sex,** race, color, ~~creed,~~ religion, ancestry, **national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information,** marital status, **gender, gender identity,** sexual orientation, **or identification with any other persons or groups defined in Penal Code 422.56** ~~national origin, age, sex, or physical or mental handicap~~ in accordance with **the statues identified in Exhibit E, Attachment 2, Provision 27 below, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations.** ~~Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations.~~ For the purpose of this D-SNP Contract, discrimination~~s on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap~~ **may** include, but ~~are~~ **is** not limited to, the following:

1) Denying any Member ~~case management services~~**any Covered Services**;

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

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

~~2)~~**4)** Restricting a Member in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or a beneficiary eligible for enrollment into the Contractor's D-SNP differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

~~3)~~**5)** The assignment of times or places for the provision of services on the basis of the ~~race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability of the participants to be served.~~ **sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56.**

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

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

D-SNP Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to ~~race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, except where~~ **sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or identification with any other persons or groups defined in Penal Code 422.56, except as needed to provide equal access to Limited English Proficient (LEP) Members or Members with disabilities, or as** medically indicated.

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

B. Discrimination Related To Health Status

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

~~C. Discrimination Complaints~~

~~Contractor agrees that copies of all grievances alleging discrimination against Members or beneficiaries eligible for enrollment into the Contractor's D-SNP because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, will be forwarded to DHCS for review and appropriate action.~~

27. Federal and State Nondiscrimination Requirements

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

28. D-SNP Contractor shall process a grievance for discrimination as required by federal and state law as stated in 45 CFR sections 84.7 and 92.7; 34 CFR section 106.8; 28 CFR section 35.107; and, to the extent applicable, W&I Code section 14029.91(e)(4).

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

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

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

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

1) The original discrimination grievance;

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

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

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

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

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

D. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination notice, and (2) language taglines in the threshold languages and at least the top 16 non-English languages in the State, as determined by DHCS, explaining the availability of free language assistance services, including written translation and oral interpretation. The nondiscrimination notice and taglines shall include D-SNP Contractor's toll-free and TTY/TDD telephone number for obtaining these services, and shall be posted as follows:

1) In all conspicuous physical locations where D-SNP Contractor interacts with the public;

2) In a conspicuous location on D-SNP Contractor's website that is accessible on the D-SNP Contractor's home page, and in a manner that allows Members, potential enrollees, and members of the public to easily locate the information; and

3) In all significant communications and significant publications targeted to Members, potential enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (45 C.F.R. § 92.8(d)(1), (f)(1)(i)-(iii)).

E. D-SNP Contractor shall post (1) a DHCS-approved nondiscrimination statement and (2) language taglines in at least the top two non-English languages in the State (as determined by DHCS), explaining the availability of free language assistance services, and the toll-free and TTY/TDD telephone number for obtaining these services, in all significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures. (45 C.F.R. § 92.8(d)(2), (g)).

F. D-SNP Contractor's nondiscrimination notice shall include all information required by Section 92.8 of Title 45 of the Code of Federal Regulations, any additional information required by DHCS, and shall provide information on how to file a discrimination grievance with:

1) Both D-SNP Contractor and the DHCS Office of Civil Rights, if there is a concern of discrimination in the Medi-Cal program based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. (45 C.F.R. section 92.8(A)(5); W&I Code section 14029.92(e); H&S Code section 11135).

2) The United States Department of Health and Human Services Office for Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability. (45 C.F.R. section 92.8(A)(7)).

~~27. Americans with Disabilities Act of 1990 Requirements~~

~~Contractor shall comply with all applicable Federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12101 et seq.), 45 CFR 84 and 28 CFR 36. Title IX~~

~~of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.~~

~~28~~29. Disabled Veteran Business Enterprises (DVBE)

D-SNP Contractor shall comply with applicable requirements of California law relating to DVBE commencing at Section 10115 of the Public Contract Code.

~~29~~30. Word Usage

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

~~30~~31. Federal False Claims Act Compliance

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

~~Exhibit G~~
~~HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)~~

~~I. Recitals~~

~~A. This D-SNP Contract (Agreement) has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ('the HITECH Act"), 42 USC Section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations").~~

~~B. The Department of Health Care Services ("DHCS") wishes to disclose to Business Associate certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, and personal information ("PI") under state law.~~

~~C. As set forth in this Agreement, Contractor, here and after, is the Business Associate of DHCS acting on DHCS' behalf and provides services, arranges, performs or assists in the performance of functions or activities on behalf of DHCS and creates, receives, maintains, transmits, uses or discloses PHI and PI. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties."~~

~~D. The purpose of this Addendum is to protect the privacy and security of the PHI and PI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act and the HIPAA regulations, including, but not limited to, the requirement that DHCS must enter into a contract containing specific requirements with D-SNP Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR 160 and 164 and the HITECH Act.~~

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

~~II. Definitions~~

~~A. "Breach" shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.~~

~~B. "Business Associate" shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.~~

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~~Exhibit G~~
~~HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)~~

~~C. "Covered Entity" shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.~~

~~D. "Electronic Health Record" shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 USC Section 17921 and implementing regulations.~~

~~E. "Electronic Protected Health Information (ePHI)" means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR 160.103.~~

~~F. "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 160.103.~~

~~G. "Privacy Rule" shall mean the HIPAA Regulation that is found at 45 CFR 160 and 164.~~

~~H. "Personal Information" shall have the meaning given to such term in California Civil Code Section 1798.29.~~

~~I. "Protected Health Information" 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 160.103.~~

~~J. "Required by Law", as set forth under 45 CFR 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This 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, and a civil or an authorized investigative demand. It also includes 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 public benefits.~~

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K. "Secretary" means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

M. "Security Rule" shall mean the HIPAA regulation that is found at 45 CFR 160 and 164.

N. "Unsecured PHI" shall have the meaning given to such term under the HITECH Act, 42 USC Section 17932(h), any guidance issued pursuant to such Act and the HIPAA regulations.

III. Terms of Agreement

A. **Permitted Uses and Disclosures of PHI by Business Associate**

Permitted Uses and Disclosures. Except as otherwise indicated in this Addendum, Business Associate may use or disclose PHI only to perform functions, activities or services specified in this Agreement, for, or on behalf of DHCS, provided that such use or disclosure would not violate the HIPAA regulations, if done by DHCS. Any such use or disclosure must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, and the HIPAA regulations.

1) ***Specific Use and Disclosure Provisions.*** Except as otherwise indicated in this Addendum, Business Associate may:

a) ***Use and disclose for management and administration.*** 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.

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b) ***Provision of Data Aggregation Services.*** Use PHI to provide data aggregation services to DHCS. Data aggregation means the combining of PHI created or received by the Business Associate on behalf of DHCS 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 DHCS.

B. **Prohibited Uses and Disclosures**

1) 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 42 U.S.C. section 17935(a) and 45 CFR section 164.522(a).

2) Business Associate shall not directly or indirectly receive remuneration in exchange for PHI, except with the prior written consent of DHCS and as permitted by 42 U.S.C. section 17935(d)(2).

C. **Responsibilities of Business Associate**

Business Associate agrees:

1) ***Nondisclosure.*** Not to use or disclose Protected Health Information (PHI) other than as permitted or required by this Agreement or as required by law.

2) ***Safeguards.*** To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of DHCS, in compliance with 45 CFR 164.308, 164.310 and 164.312, 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 45 CFR 164, subpart C, in compliance with 45 CFR 164.316. Business Associate shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Business Associate's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Business Associate will provide DHCS with its current and updated policies.

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3) ~~***Security***. 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:~~

   a) ~~Complying with all of the data system security precautions listed in Attachment A, the Business Associate Data Security Requirements;~~

   b) ~~Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement;~~

   c) ~~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; and~~

   d) ~~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.~~

   ~~Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with DHCS.~~

4) ~~***Mitigation of Harmful Effects***. 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 Addendum.~~

5) ~~***Business Associate's Agents***.~~

   ~~To enter into written agreements with any agents, including vendors, to whom Business Associate provides PHI or PI received from or created or received by Business Associate on behalf of DHCS, that impose the same restrictions and conditions on such agents and vendors that apply to Business Associate with respect to such PHI and PI under this Addendum, and that comply with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the requirement that any agents or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI and PI. Business Associate shall incorporate, when applicable, the~~

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~~relevant provisions of this Addendum into each sub-award to such agents, and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.~~

6) ~~***Availability of Information to DHCS and Individuals.*** To provide access and information:~~

   a) ~~To provide access as DHCS may require, and in the time and manner designated by DHCS (upon reasonable notice and during Business Associate's normal business hours) to PHI in a Designated Record Set, to DHCS (or, as directed by DHCS), to an Individual, in accordance with 45 CFR 164.524. Designated Record Set means the group of records maintained for DHCS that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for DHCS health plans; or those records used to make decisions about individuals on behalf of DHCS. Business Associate shall use the forms and processes developed by DHCS for this purpose and shall respond to requests for access to records transmitted by DHCS within 15 calendar days of receipt of the request by producing the records or verifying that there are none.~~

   b) ~~If Business Associate maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Business Associate shall provide such information in an electronic format to enable DHCS to fulfill its obligations under the HITECH Act, including but not limited to, 42 USC Section 17935(e).~~

   c) ~~If Business Associate receives data from DHCS that was provided to DHCS by the Social Security Administration, upon request by DHCS, Business Associate shall provide DHCS with a list of all employees, contractors and agents who have access to the Social Security data, including employees, contractors and agents.~~

7) ~~***Amendment of PHI.*** To make any amendment(s) to PHI that DHCS directs or agrees to pursuant to 45 CFR 164.526, in the time and manner designated by DHCS.~~

8) ~~***Internal Practices.*** To make Business Associate's internal practices, books and records relating to the use and disclosure of PHI received from DHCS, or created or received by Business Associate on behalf of DHCS, available to DHCS or to the Secretary of the U.S. Department of Health and Human Services in a time and manner designated by DHCS or by the Secretary, for purposes of determining DHCS' compliance with the HIPAA regulations. If any~~

~~information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Business Associate, Business Associate shall so certify to DHCS and shall set forth the efforts it made to obtain the information.~~

9) ~~***Documentation of Disclosures.*** To document and make available to DHCS or (at the direction of DHCS) 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 the HITECH Act and its implementing regulations, including but not limited to 45 CFR 164.528 and 42 USC Section 17935(c). If Business Associate maintains electronic health records for DHCS as of January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after January 1, 2014. If Business Associate acquires electronic health records for DHCS after January 1, 2009, Business Associate must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations, effective with disclosures on or after the date the electronic health record is acquired, or on or after January 1, 2011, whichever date is later. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.~~

10) ~~***Breaches and Security Incidents.*** During the term of this Agreement, Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:~~

a) ~~To notify DHCS **immediately by telephone call plus email or fax** upon the discovery of a breach of unsecured PHI or PI in electronic media or in any other media if the PHI or PI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon the discovery of a suspected security incident that involves data provided to DHCS by the Social Security Administration.~~

b) ~~To notify DHCS **within 24 hours by email 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 and this Addendum, or potential loss of confidential data affecting this Agreement. 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 (other than the person committing the breach) who is an employee, officer or other agent of Business Associate.~~

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c) ~~Notice shall be provided to the DHCS Program Contract Manager, the DHCS Privacy Officer and the DHCS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the DHCS ITSD Service Desk. Notice shall be made using the "DHCS Privacy Incident Report" form, including all information known at the time. Business Associate shall use the most current version of this form, which is posted on the DHCS Privacy Office website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Use" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssoci atesOnly.aspx~~

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

i. ~~Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and~~

ii. ~~Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.~~

e) ~~***Investigation and Investigation Report.*** To immediately investigate such security incident, breach, or unauthorized access, use or disclosure of PHI or PI. Within 72 hours of the discovery, Business Associate shall submit an updated "DHCS Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer:~~

f) ~~***Complete Report.*** To provide a complete report of the investigation to the DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "DHCS Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, the HIPAA regulations and/or state law. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that listed on the "DHCS Privacy Incident Report" form, Business Associate shall make~~

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~~reasonable efforts to provide DHCS with such information. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "DHCS Privacy Incident Report" form. DHCS will review and approve the determination of whether a breach occurred and individual notifications are required, and the corrective action plan.~~

g) ~~***Notification of Individuals.*** If the cause of a breach of PHI or PI is attributable to Business Associate or agents or vendors, Business Associate shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law and shall pay any costs of such notifications, as well as any costs associated with the breach. The notifications shall comply with the requirements set forth in 42 USC Section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days. The DHCS Program Contract Manager, the DHCS Privacy Officer, and the DHCS Information Security Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.~~

h) ~~***Responsibility for Reporting of Breaches.*** If the cause of a breach of PHI or PI is attributable to Business Associate or its agents, or vendors, Business Associate is responsible for all required reporting of the breach as specified in 42 USC Section 17932 and its implementing regulations, including notification to media outlets and to the Secretary. If a breach of unsecured PHI involves more than 500 residents of the State of California or its jurisdiction, Business Associate shall notify the Secretary of the breach immediately upon discovery of the breach. If Business Associate has reason to believe that duplicate reporting of the same breach or incident may occur because its agents or vendors may report the breach or incident to DHCS in addition to Business Associate, Business Associate shall notify DHCS, and DHCS and Business Associate may take appropriate action to prevent duplicate reporting. The breach reporting requirements of this paragraph are in addition to the reporting requirements set forth in subsection 1, above.~~

i) ~~***DHCS Contact Information.*** To direct communications to the above referenced DHCS staff, the D-SNP Contractor shall initiate contact as indicated herein. DHCS reserves the right to make changes to the contact information below by giving written notice to the D-SNP Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.~~

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DHCS Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Scope of Work exhibit for Program Contract Manager information	Privacy Officer c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: privacyofficer@dhcs.ca.gov Telephone: (916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Fax: (916) 440-5537 Telephone: ITSD Service Desk (916) 440-7000 or (800) 579-0874

11. ***Termination of Agreement.*** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Business Associate knows of a material breach or violation by DHCS of this Addendum, it shall take the following steps:

    a) Provide an opportunity for DHCS to cure the breach or end the violation and terminate the Agreement if DHCS does not cure the breach or end the violation within the time specified by Business Associate; or

    b) Immediately terminate the Agreement if DHCS has breached a material term of the Addendum and cure is not possible.

12. ***Due Diligence.*** Business Associate shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Addendum and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and that its agents and vendors are in compliance with their obligations as required by this Addendum.

13. ***Sanctions and/or Penalties***. Business Associate understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Business Associate may result in the imposition of sanctions and/or penalties on Business Associate under HIPAA, the HITECH Act and the HIPAA regulations.

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IV. Obligations of DHCS

DHCS agrees to:

A. ***Notice of Privacy Practices.*** Provide Business Associate with the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR 164.520, as well as any changes to such notice. Visit the DHCS Privacy Office to view the most current Notice of Privacy Practices at: 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).

B. ***Permission by Individuals for Use and Disclosure of PHI.*** Provide the 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.

C. ***Notification of Restrictions.*** Notify the Business Associate of any restriction to the use or disclosure of PHI that DHCS has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect the Business Associate's use or disclosure of PHI.

D. ***Requests Conflicting with HIPAA Rules.*** Not request the Business Associate to use or disclose PHI in any manner that would not be permissible under the HIPAA regulations if done by DHCS.

V. Audits, Inspection and Enforcement

A. From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement and this Addendum. Business Associate shall promptly remedy any violation of any provision of this Addendum and shall certify the same to the DHCS Privacy Officer in writing. The fact that DHCS 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 Addendum, nor does DHCS':

1) Failure to detect or

2) 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 DHCS' enforcement rights under this Agreement and this Addendum.

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B. If Business Associate is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office of Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Addendum, Business Associate shall notify DHCS and provide DHCS with a copy of any PHI or PI that Business Associate provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI or PI to the Secretary. Business Associate is responsible for any civil penalties assessed due to an audit or investigation of Business Associate, in accordance with 42 U.S.C. section 17934(c).

VI. Termination

A. ***Term.*** The Term of this Addendum shall commence as of the effective date of this Addendum and shall extend beyond the termination of the contract and shall terminate when all the PHI provided by DHCS to Business Associate, or created or received by Business Associate on behalf of DHCS, is destroyed or returned to DHCS, in accordance with 45 CFR 164.504(e)(2)(ii)(I).

B. ***Termination for Cause.*** In accordance with 45 CFR 164.504(e)(1)(ii), upon DHCS' knowledge of a material breach or violation of this Addendum by Business Associate, DHCS shall:

1) 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 DHCS; or

2) Immediately terminate this Agreement if Business Associate has breached a material term of this Addendum and cure is not possible.

C. ***Judicial or Administrative Proceedings.*** Business Associate will notify DHCS if it is named as a defendant in a criminal proceeding for a violation of HIPAA. DHCS may terminate this Agreement if Business Associate is found guilty of a criminal violation of HIPAA. DHCS may terminate this Agreement if a finding or stipulation that the Business Associate has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Business Associate is a party or has been joined.

D. ***Effect of Termination.*** Upon termination or expiration of this Agreement for any reason, Business Associate shall return or destroy all PHI received from DHCS (or created or received by Business Associate on behalf of DHCS) that Business Associate still maintains in any form, and shall retain no copies of such PHI. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. Business Associate shall continue to

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extend the protections of this Addendum to such PHI, and shall limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. This provision shall apply to PHI that is in the possession of agents of Business Associate.

VII. Miscellaneous Provisions

A. ***Disclaimer.*** DHCS makes no warranty or representation that compliance by Business Associate with this Addendum, HIPAA or the HIPAA regulations 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 safeguarding of PHI.

B. ***Amendment.*** The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon DHCS' request, Business Associate agrees to promptly enter into negotiations with DHCS concerning an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the HIPAA regulations or other applicable laws. DHCS may terminate this Agreement upon 30 days written notice in the event:

1) Business Associate does not promptly enter into negotiations to amend this Addendum when requested by DHCS pursuant to this Section; or

2) Business Associate does not enter into an amendment providing assurances regarding the safeguarding of PHI that DHCS in its sole discretion deems sufficient to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

C. ***Assistance in Litigation or Administrative Proceedings.*** Business Associate shall make itself and any employees or agents assisting Business Associate in the performance of its obligations under this Agreement, available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inactions or actions by the Business Associate, except where Business Associate or its employee or agent is a named adverse party.

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

~~E. ***Interpretation***. The terms and conditions in this Addendum shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the HIPAA regulations and applicable state laws. The parties agree that any ambiguity in the terms and conditions of this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations.~~

~~F. ***Regulatory References.*** A reference in the terms and conditions of this Addendum to a section in the HIPAA regulations means the section as in effect or as amended.~~

~~G. ***Survival.*** The respective rights and obligations of Business Associate under Section VI.D of this Addendum shall survive the termination or expiration of this Agreement.~~

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

Exhibit G, Attachment A
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I. Personnel Controls

A. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. ***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. The statement must be renewed annually. Business Associate shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. Business Associate shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls

A. ***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 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in

place to protect that data, based upon a risk assessment/system security review.

C. ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

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

E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. ***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 30 days of vendor release.

G. ***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. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 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:

1) Upper case letters (A-Z)

2) Lower case letters (a-z)

3) Arabic numerals (0-9)

4) Non-alphanumeric characters (punctuation symbols)

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H. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be wiped using the Gutmann or US Department of Defense (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 the DHCS Information Security Office.

I. ***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.

J. ***Warning Banners.*** All systems providing access to 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 by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. ***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.

L. ***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.

M. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit 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.

N. ***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.

Exhibit G, Attachment A
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III. Audit Controls

A. ***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.

B. ***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.

C. ***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

A. ***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 this Agreement for more than 24 hours.

B. Data Backup Plan. Business Associate must have established documented procedures to backup DHCS PHI 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 an estimate of the amount of time needed 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 DHCS data.

V. Paper Document Controls

A. ***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 or PI 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.

Exhibit G, Attachment A
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

B. ***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.

C. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Business Associate except with express written permission of DHCS.

E. ***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 the fax.

F. ***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 includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.

Exhibit G
Business Associate Addendum

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

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

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

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

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

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

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

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

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

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

8. **Compliance with Other Applicable Law**

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

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

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

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

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

9. Additional Responsibilities of Business Associate

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

9.2 Safeguards and Security.

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

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

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

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

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

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.1 Notice to DHCS.

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

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

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

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

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

18.1.2.4 Potential loss of confidential data affecting this Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

20. Audits, Inspection and Enforcement

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

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

21. Termination

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

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

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

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

22. Miscellaneous Provisions

22.1 Disclaimer. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business

Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. Amendment.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 Assistance in Litigation or Administrative Proceedings. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 No Third-Party Beneficiaries. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 Interpretation. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

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

Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Acupuncture Services	Other Practitioners' Services and Acupuncture Services	Acupuncture services shall be limited to treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Acute Administrative Days	Intermediate Care Facility Services	Acute administrative days are covered, when authorized by a Medi-Cal consultant subject to the acute inpatient facility has made appropriate and timely discharge planning, all other coverage has been utilized and the acute inpatient facility meets the requirements contained in the Manual of Criteria for Medi-Cal Authorization.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Blood and Blood Derivatives	Blood and Blood Derivatives	A facility that collects, stores, and distributes human blood and blood derivatives. Covers certification of blood ordered by a physician or facility where transfusion is given.	X	X	X	X	X	X
California Children Services (CCS)	Service is not covered under the State Plan	California Children Services (CCS) means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.			X[6]			
Certified Family nurse practitioner	Certified Family Nurse Practitioners' Services	A certified family nurse practitioners who provide services within the scope of their practice.	X	X	X	X	X	X
Certified Pediatric Nurse Practitioner Services	Certified Pediatric Nurse Practitioner Services	Covers the care of mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks; can also include primary care services.	X	X	X	X	X	X
Child Health and Disability Prevention (CHDP) Program		A preventive program that delivers periodic health assessments and provides care coordination to assist with medical appointment scheduling, transportation, and access to diagnostic and treatment services.	X	X	X[4]	X	X	X
Childhood Lead Poisoning Case Management (Provided by the Local County Health Departments)		A case of childhood lead poisoning (for purposes of initiating case management) as a child from birth up to 21 years of age with one venous blood lead level (BLL) equal to or greater than 20 µg/dL, or two BLLs equal to or greater than 15 µg/dL that must be at least 30 and no more than 600 calendar days apart, the first specimen is not required to be venous, but the second must be venous.						
Chiropractic Services	Chiropractors' Services	Services provided by chiropractors, acting within the scope of their practice as authorized by California law, are covered, except that such services shall be limited to treatment of the spine by means of manual manipulation.	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Chronic Hemodialysis	Chronic Hemodialysis	Procedure used to treat kidney failure - covered only as an outpatient service. Blood is removed from the body through a vein and circulated through a machine that filters the waste products and excess fluids from the blood. The "cleaned" blood is then returned to the body. Chronic means this procedure is performed on a regular basis. Prior authorization required when provided by renal dialysis centers or community hemodialysis units.	**X**	**X**	**X**	**X**	**X**	**X**
Community Based Adult Services (CBAS)		CBAS Bundled services: An outpatient, facility based service program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, meals and transportation to eligible Medi-Cal beneficiaries. CBAS Unbundled Services: Component parts of CBAS center services delivered outside of centers, under certain conditions, as specified in paragraph 94.	**X**	**X**	**X**	**X**	**X**	**X**
Comprehensive Perinatal Services	Extended Services for Pregnant Women-Pregnancy Related and Postpartum Services	Comprehensive perinatal services means obstetrical, psychosocial, nutrition, and health education services, and related case coordination provided by or under the personal supervision of a physician during pregnancy and 60 days following delivery.	**X**	**X**	**X**	**X**	**X**	**X**
Dental Services		Professional services performed or provided by dentists including diagnosis and treatment of malposed human teeth, of disease or defects of the alveolar process, gums, jaws and associated structures; the use of drugs, anesthetics and physical evaluation; consultations; home, office and institutional calls.						
Drug Medi-Cal Substance Abuse Services	Substance Abuse Treatment Services	Medically necessary substance abuse treatment to eligible beneficiaries.						
Durable Medical Equipment	DME	Assistive medical devices and supplies. Covered with a prescription; prior authorization is required.	**X**	**X**	**X**	**X**	**X**	**X**

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services and EPSDT Supplemental Services	EPSDT	Preliminary evaluation to help identify potential health issues.	X	X	X	X	X	X
Enhanced Case Management (ECM), as defined in paragraph 95		A service consisting of those "Complex Case Management" and "Person-Centered Planning" services including the coordination of beneficiaries' individual needs for needed long-term care services and supports.	X	X	X	X	X	X
Erectile Dysfunction Drugs		FDA-approved drugs that may be prescribed if a male patient experiences an inability or difficulty getting or keeping an erection as a result of a physical problem.						
Expanded Alpha-Fetoprotein Testing (Administered by the Genetic Disease Branch of DHCS)		A simple blood test recommended for all pregnant women to detect if they are carrying a fetus with certain genetic abnormalities such as open neural tube defects, Down Syndrome, chromosomal abnormalities, and defects in the abdominal wall of the fetus.						
Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes and Other Eye Appliances	Eyeglasses, Contact Lenses, Low Vision Aids, Prosthetic Eyes, and Other Eye Appliances	Eye appliances are covered on the written prescription of a physician or optometrist.	X[1,3]	X[1,3]	X[1,3]	X[1,3]	X[1,3]	X[1,3]
Federally Qualified Health Centers (FQHC) (Medi-Cal covered services only)	FQHC	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).	X	X	X	X	X	X
Hearing Aids	Hearing Aids	Hearing aids are covered only when supplied by a hearing aid dispenser on prescription of an otolaryngologist, or the attending physician where there is no otolaryngologist available in the community, plus an audiological evaluation including a hearing aid evaluation which must be performed by or under the supervision of the above physician or by a licensed audiologist.	X	X	X	X	X	X

Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Home and Community-Based Waiver Services (Does not include EPSDT Services)		Home and community-based waiver services shall be provided and reimbursed as Medi-Cal covered benefits only: (1) For the duration of the applicable federally approved waiver, (2) To the extent the services are set forth in the applicable waiver approved by the HHS; and (3) To the extent the Department can claim and be reimbursed federal funds for these services.						
Home Health Agency Services	Home Health Services-Home Health Agency	Home health agency services are covered as specified below when prescribed by a physician and provided at the home of the beneficiary in accordance with a written treatment plan which the physician reviews every 60 days.	**X**	**X**	**X**	**X**	**X**	**X**
Home Health Aide Services	Home Health Services-Home Health Aide	Covers skilled nursing or other professional services in the residence including part-time and intermittent skilled nursing services, home health aid services, physical therapy, occupational therapy, or speech therapy and audiology services, and medical social services by a social worker.	**X**	**X**	**X**	**X**	**X**	**X**
Hospice Care	Hospice Care	Covers services limited to individuals who have been certified as terminally ill in accordance with Title 42, CFR Part 418, Subpart B, and who directly or through their representative volunteer to receive such benefits in lieu of other care as specified.	**X**	**X**	**X**	**X**	**X**	**X**
Hospital Outpatient Department Services and Organized Outpatient Clinic Services	Clinic Services and Hospital Outpatient Department Services and Organized Outpatient Clinic Services	A scheduled administrative arrangement enabling outpatients to receive the attention of a healthcare provider. Provides the opportunity for consultation, investigation and minor treatment.	**X**	**X**	**X**	**X**	**X**	**X**
Human Immunodeficiency Virus and AIDS drugs		Human Immunodeficiency Virus and AIDS drugs that are listed in the Medi-Cal Provider Manual			**X**[7]			

Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Hysterectomy	Inpatient Hospital Services	Except for previously sterile women, a nonemergency hysterectomy may be covered only if: (1) The person who secures the authorization to perform the hysterectomy has informed the individual and the individual's representatives, if any, orally and in writing, that the hysterectomy will render the individual permanently sterile, (2) The individual and the individual's representative, if any, has signed a written acknowledgment of the receipt of the information in and (3) The individual has been informed of the rights to consultation by a second physician. An emergency hysterectomy may be covered only if the physician certifies on the claim form or an attachment that the hysterectomy was performed because of a life-threatening emergency situation in which the physician determined that prior acknowledgement was not possible and includes a description of the nature of the emergency.			**X**			
Indian Health Services (Medi-Cal covered services only)		Indian means any person who is eligible under federal law and regulations (25 U.S.C. Sections 1603c, 1679b, and 1680c) and covers health services provided directly by the United States Department of Health and Human Services, Indian Health Service, or by a tribal or an urban Indian health program funded by the Indian Health Service to provide health services to eligible individuals either directly or by contract.	**X**	**X**	**X**	**X**	**X**	**X**
In-Home Medical Care Waiver Services and Nursing Facility Waiver Services	.	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	**X**	**X**	**X**	**X**	**X**
Inpatient Hospital Services	Inpatient Hospital Services	Covers delivery services and hospitalization for newborns; emergency services without prior authorization; and any hospitalization deemed medically necessary with prior authorization.	**X**	**X**	**X**	**X**	**X**	**X**

Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Facility Services for the Developmentally Disabled	Intermediate Care Facility Services for the Developmentally Disabled	Intermediate care facility services for the developmentally disabled are covered subject to prior authorization by the Department. Authorizations may be granted for up to six months. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care	X[5]	X[5]	X	X[5]	X[5]	X[5]
Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate Care Facility Services for the Developmentally Disabled Habilitative	Intermediate care facility services for the developmentally disabled habilitative (ICF-DDH) are covered subject to prior authorization by the Department of Health Services for the ICF-DDH level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF-DDH or for continuation of services shall be initiated by the facility on forms designated by the Department. Certification documentation required by the Department of Developmental Services must be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Intermediate Care Facility Services for the Developmentally Disabled-Nursing.		Intermediate care facility services for the developmentally disabled-nursing (ICF/DD-N) are covered subject to prior authorization by the Department for the ICF/DD-N level of care. Authorizations may be granted for up to six months. Requests for prior authorization of admission to an ICF/DD-N or for continuation of services shall be initiated by the facility on Certification for Special Treatment Program Services forms (HS 231). Certification documentation required by the Department of Developmental Services shall be completed by regional center personnel and submitted with the Treatment Authorization Request form. The attending physician shall sign the Treatment Authorization Request form and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]

Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Intermediate Care Services	Intermediate Care Facility Services	Intermediate care services are covered only after prior authorization has been obtained from the designated Medi-Cal consultant for the district where the facility is located. The authorization request shall be initiated by the facility. The attending physician shall sign the authorization request and shall certify to the Department that the beneficiary requires this level of care.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Laboratory, Radiological and Radioisotope Services	Laboratory, X-Ray and Laboratory, Radiological and Radioisotope Services	Covers exams, tests, and therapeutic services ordered by a licensed practitioner	X	X	X	X	X	X
Licensed Midwife Services	Other Practitioners' Services and Licensed Midwife Services	The following services shall be covered as licensed midwife services under the Medi-Cal Program when provided by a licensed midwife supervised by a licensed physician and surgeon: (1) Attendance at cases of normal childbirth and (2) The provision of prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn.	X	X	X	X	X	X

Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Local Educational Agency (LEA) Services	Local Education Agency Medi-Cal Billing Option Program Services	LEA health and mental health evaluation and health and mental health education services, which include any or all of the following: (A) Nutritional assessment and nutrition education, consisting of assessments and non-classroom nutrition education delivered to the LEA eligible beneficiary based on the outcome of the nutritional health assessment (diet, feeding, laboratory values, and growth), (B) Vision assessment, consisting of examination of visual acuity at the far point conducted by means of the Snellen Test, (C) Hearing assessment, consisting of testing for auditory impairment using at-risk criteria and appropriate screening techniques as defined in Title 17, California Code of Regulations, Sections 2951(c), (D) Developmental assessment, consisting of examination of the developmental level by review of developmental achievement in comparison with expected norms for age and background, (E) Assessment of psychosocial status, consisting of appraisal of cognitive, emotional, social, and behavioral functioning and self-concept through tests, interviews, and behavioral evaluations and (F) Health education and anticipatory guidance appropriate to age and health status, consisting of non-classroom health education and anticipatory guidance based on age and developmentally appropriate health education.						
Long Term Care (LTC)		Care in a facility for longer than the month of admission plus one month.	**X**[5]	**X**[5]	**X**	**X**[5]	**X**[5]	**X**[5]
Medical Supplies	Medical Supplies	Medically necessary supplies when prescribed by a licensed practitioner. Does not include incontinence creams and washes	**X**	**X**	**X**	**X**	**X**	**X**
Medical Transportation Services	Transportation-Medical Transportation Services	Covers ambulance, litter van and wheelchair van medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care.	**X**	**X**	**X**	**X**	**X**	**X**
Multipurpose Senior Services Program (MSSP)		MSSP sites provide social and health care management for frail elderly clients who are certifiable for placement in a nursing facility but who wish to remain in the community.						
Nurse Anesthetist Services	Other Practitioners' Services and Nurse Anesthetist Services	Covers anesthesiology services performed by a nurse anesthetist within the scope of his or her licensure.	**X**	**X**	**X**	**X**	**X**	**X**

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Nurse Midwife Services	Nurse-Midwife Services	An advanced practice registered nurse who has specialized education and training in both Nursing and Midwifery, is trained in obstetrics, works under the supervision of an obstetrician, and provides care for mothers and newborns through the maternity cycle of pregnancy, labor, birth, and the immediate postpartum period, not to exceed six weeks.	**X**	**X**	**X**	**X**	**X**	**X**
Optometry Services	Optometrists' Services	Covers eye examinations and prescriptions for corrective lenses. Further services are not covered.	**X**	**X**	**X**	**X**	**X**	**X**
Outpatient Mental Health	Outpatient Mental Health	Services provided by licensed health care professionals acting within the scope of their license for adults and children diagnosed with a mental condition as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Services include: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient Services for the purpose of monitoring drug therapy • Outpatient laboratory, drugs, supplies and supplements • Screening and Brief Intervention (SBI) • Psychiatric consultation for medication management	**X**[2]	**X**[2]	**X**[2]	**X**[2]	**X**[2]	**X**[2]
Organized Outpatient Clinic Services	Clinic Services and Organized Outpatient Clinic Services	In-home medical care waiver services and nursing facility waiver services are covered when prescribed by a physician and provided at the beneficiary's place of residence in accordance with a written treatment plan indicating the need for in-home medical care waiver services or nursing facility waiver services and in accordance with a written agreement between the Department and the provider of service.	**X**	**X**	**X**	**X**	**X**	**X**

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Outpatient Heroin Detoxification Services	Outpatient Heroin Detoxification Services	Can cover of a number of medications and treatments, allowing for day to day functionality for a person choosing to not admit as an inpatient. Routine elective heroin detoxification services are covered, subject to prior authorization, only as an outpatient service. Outpatient services are limited to a maximum period of 21 days. Inpatient hospital services shall be limited to patients with serious medical complications of addiction or to patients with associated medical problems which require inpatient treatment.						
Part D Drugs		Drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act.						
Pediatric Subacute Care Services	Nursing Facility Services and Pediatric Subacute Services (NF)	Pediatric Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	**X**[5]	**X**[5]	**X**	**X**[5]	**X**[5]	**X**[5]
Personal Care Services	Personal Care Services	Covers services which may be provided only to a categorically needy beneficiary who has a chronic, disabling condition that causes functional impairment that is expected to last at least 12 consecutive months or that is expected to result in death within 12 months and who is unable to remain safely at home without the services.						
Pharmaceutical Services and Prescribed Drugs	Pharmaceutical Services and Prescribed Drugs	Covers medications including prescription and nonprescription and total parental nutrition supplied by licensed physician.	**X**	**X**	**X**	**X**	**X**	**X**
Physician Services	Physician Services	Covers primary care, outpatient services, and services rendered during a stay in a hospital or nursing facility for medically necessary services. Can cover limited mental health services when rendered by a physician, and limited allergy treatments.	**X**	**X**	**X**	**X**	**X**	**X**
Podiatry Services	Other Practioners' Services and Podiatrists' Services	Office visits are covered if medically necessary. All other outpatient services are subject to prior authorization and are limited to medical and surgical services necessary to treat disorders of the feet, ankles, or tendons that insert into the foot, secondary to or complicating chronic medical diseases, or which significantly impair the ability to walk. Services rendered on an emergency basis are exempt from prior authorization.	**X**[1]	**X**[1]	**X**[1]	**X**[1]	**X**[1]	**X**[1]

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Prosthetic and Orthotic Appliances	Prosthetic and Orthodic Appliances	All prosthetic and orthotic appliances necessary for the restoration of function or replacement of body parts as prescribed by a licensed physician, podiatrist or dentist, within the scope of their license, are covered when provided by a prosthetist, orthotist or the licensed practitioner, respectively	X	X	X	X	X	X
Physical Therapy, Occupational Therapy, Speech Pathology and Audiological Services	Physical Therapy, Occupational Therapy, Speech Pathology, and Audiology Services	Physical therapy, occupational therapy, speech pathology and audiological services are covered when provided by persons who meet the appropriate requirements	X[1]	X[1]	X[1]	X[1]	X[1]	X[1]
Psychotherapeutic drugs	Services not covered under the State Plan	S. Psychotherapeutic drugs that are listed in the Medi-Cal Provider Manual			X[8]			
Rehabilitation Center Outpatient Services	Rehabilitative Services	A facility providing therapy and training for rehabilitation. The center may offer occupational therapy, physical therapy, vocational training, and special training	X	X	X	X	X	X
Rehabilitation Center Services	Rehabilitative Services	A facility which provides an integrated multidisciplinary program of restorative services designed to upgrade or maintain the physical functioning of patients.	X	X	X	X	X	X
Renal Homotransplantation	Organ Transplant Services	Renal homotransplantation is covered only when performed in a hospital which meets the standards established by the Department for renal homotransplantation centers.	X	X	X	X	X	X
Requirements Applicable to EPSDT Supplemental Services.	EPSDT	Early and Periodic Screening, Diagnosis and Treatment: for beneficiaries under 21 years of age; includes case management and supplemental nursing services; also covered by CCS for CCS services, and Mental Health services.	X	X	X	X	X	X
Respiratory Care Services	Respiratory Care Services	A provider trained and licensed for respiratory care to provide therapy, management, rehabilitation, diagnostic evaluation, and care of patients with deficiencies and abnormalities affecting the pulmonary system and aspects of cardiopulmonary and other systems.	X	X	X	X	X	X
Rural Health Clinic Services	Rural Health Clinic Services	Covers primary care services by a physician or a non-physician medical practitioner, as well as any supplies incident to these services; home nursing services; and any other outpatient services, supplies, supplies, equipment and drugs.	X	X	X	X	X	X
Scope of Sign Language Interpreter Services	Sign Language Interpreter Services	Sign language interpreter services may be utilized for medically necessary health care services	X	X	X	X	X	X

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Services provided in a State or Federal Hospital		California state hospitals provide inpatient treatment services for Californians with serious mental illnesses. Federal hospitals provide services for certain populations, such as the military, for which the federal government is responsible.						
Short-Doyle Mental Health Medi-Cal Program Services	Short-Doyle Program	Community mental health services provided by Short-Doyle Medi-Cal providers to Medi-Cal beneficiaries are covered by the Medi-Cal program.						
Skilled Nursing Facility Services	Nursing Facility Services and Skilled Nursing Facility Services	A skilled nursing facility is any institution, place, building, or agency which is licensed as a SNF by DHCS or is a distinct part or unit of a hospital, (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by DHCS for participation as a SNF in the Medi-Cal program.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Special Duty Nursing	Private Duty Nursing Services	Private duty nursing is the planning of care and care of clients by nurses, whether an registered nurse or licensed practical nurse.	X	X	X	X	X	X
Specialty Mental health services		Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services.						
Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities	Special Rehabilitative Services	Specialized rehabilitative services shall be covered. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either (1) a sustained higher level of self care and discharge to home or (2) a lower level of care. Specialized rehabilitation service shall be covered.	X[5]	X[5]	X	X[5]	X[5]	X[5]
State Supported Services		State funded abortion services that are provided through a secondary contract.	X	X	X	X	X	X
Subacute Care Services	Nursing Facility Services and Skilled Subacute Care Services SNF	Subacute care services are a type of skilled nursing facility service which is provided by a subacute care unit.	X[5]	X[5]	X	X[5]	X[5]	X[5]
Swing Bed Services	Inpatient Hospital Services	Swing bed services is additional inpatient care services for those who qualify and need additional care before returning home.	X	X	X	X	X	X
Targeted Case Management Services Program	Targeted Case Management	Persons who are eligible to receive targeted case management services shall consist of the following Medi-Cal beneficiary groups: high risk, persons who have language or other comprehension barriers and persons who are 18 years of age and older.						

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Exhibit H – Medi-Cal Benefits and Covered Services

Service	State Plan Service Category	Definition	GMC	Two-Plan	COHS	Regional	Imperial	San Benito
Targeted Case Management Services.	Targeted Case Management	Targeted case management services shall include at least one of the following service components: A documented assessment identifying the beneficiary's needs, development of a comprehensive, written, individual service plan, implementation of the service plan includes linkage and consultation with and referral to providers of service, assistance with accessing the services identified in the service plan, crisis assistance planning to coordinate and arrange immediate service or treatment needed in those situations that appear to be emergent in nature or which require immediate attention or resolution in order to avoid, eliminate or reduce a crisis situation for a specific beneficiary, periodic review of the beneficiary's progress toward achieving the service outcomes identified in the service plan to determine whether current services should be continued, modified or discontinued.						
Transitional Inpatient Care Services	Nursing Facility and Transitional Inpatient Care Services	Focus on transition of care from outpatient to inpatient. Inpatient care coordinators, along with providers from varying settings along the care continuum, should provide a safe and quality transition.	**X**	**X**	**X**	**X**	**X**	**X**
Tuberculosis (TB) Related Services	TB Related Services	Covers TB care and treatment in compliance with the guidelines recommended by American Thoracic Society and the Centers for Disease Control and Prevention.						

[1] Optional benefits coverage is limited to only beneficiaries in "Exempt Groups": 1) beneficiaries under 21 years of age for services rendered pursuant to EPSDT program; 2) beneficiaries residing in a SNF (Nursing Facilities Level A and Level B, including subacute care facilities; 3) beneficiaries who are pregnant; 4) CCS beneficiaries; and 5) beneficiaries enrolled in the PACE. Services include: Chiropractic Services, Acupuncturist, Audiologist and Audiology Services, Optician and Optical Fabricating Lab, Dental*, Speech Pathology, Dentures, Eye glasses.

[2] Services may be provided by primary care physicians, psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health providers. Solano County for Partnership Health plan (COHS) covers specialty mental health, and Kaiser GMC covers inpatient, outpatient, and specialty mental health services.

[3] Fabrication of optical lenses only covered by CenCal Health.
[4] Not covered by CenCal
[5] Only covered for the month of admission and the following month

[6] Not Covered by CalOptima, Central California Alliance for Health, Partnership HealthPlan of California (Sonoma County Only) and CenCal (San Luis Obispo County Only)
[7] Only covered in Health Plan of San Mateo and CalOptima
[8] Only covered in Health Plan of San Mateo

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Authorizing Execution of Amendment to Agreement with the California Department of Health Care Services in Order to Continue Operation of the OneCare and OneCare Connect Programs

Contact

Silver Ho, Executive Director of Compliance, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to Agreement 16-93274 between CalOptima and the California Department of Health Care Services (DHCS) in order to continue operation of the OneCare and OneCare Connect programs.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into new five-year Primary and Secondary Agreements with DHCS that have been subsequently extended and amended. Amendments to these agreements are summarized in the attached appendix. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman of CalOptima's Board of Directors executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman has executed three amendments to extend the contract termination date, pursuant to Board authority. Agreement 16-93274 is set to terminate on December 31, 2020. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274

DHCS has notified CalOptima of its intention to provide CalOptima with a forthcoming amendment to extend Agreement 16-93274 for an additional year, through December 31, 2021. CalOptima has requested that DHCS send the amendment to CalOptima as soon as possible, in order to allow for immediate signature by CalOptima and prompt return to DHCS for countersignature.

The Centers for Medicare & Medicaid Services (CMS) requires that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2021 contract year no later than July 6, 2020. Executing Amendment 04 (A-04) to Agreement 16-93274 is required in order

for CalOptima to meet CMS's filing requirements, and to continue to operate CalOptima's D-SNP "OneCare" and its Cal MediConnect program "OneCare Connect" in contract year 2021.

The amendment is expected to contain language changes in addition to the extension of the expiration date. The language changes were not available as of the date that materials were due for the June 2020 meeting of the CalOptima Board of Directors but are expected within the next several weeks, if not sooner. Staff expects DHCS to propose language changes to the contract to meet the requirements contained in the October 7, 2019 CMS memorandum entitled "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)." After DHCS's proposed language changes have been received, staff will return to the Board to request a revised and updated authority as a matter of ratification.

Fiscal Impact
The recommended action to execute an Amendment to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral.

Rationale for Recommendation
CalOptima's execution of Amendment 04 (A-04) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare and OneCare Connect programs during 2021.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Appendix summary of amendments to Agreements with DHCS
2. CMS Memorandum "CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)"

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

APPENDIX TO AGENDA ITEM 14

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

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

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to **Medicare Improvements for Patients and Providers Act** (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017
A–35 incorporates Managed Long–Term Services and Supports (MLTSS) into CalOptima's Primary Agreement with the DHCS.	March 6, 2014 February 2, 2017
A–36 incorporates revised base rates for July 2015 to June 2016.	December 7, 2017
A–37 incorporates revised base rates for July 2016 to June 2017.	February 7, 2019
A–38 incorporates full dual rates for Calendar Year (CY) 2015	August 1, 2019
A–39 incorporates full dual rates for Calendar Year (CY) 2016	August 1, 2019
A-40 incorporates Final Rule contract language.	June 1, 2017 February 6, 2020
A-41 incorporates base rates for July 2017 to June 2018, Transportation, American Indian Health Program, Mental Health Parity, CCI updates and Adult Expansion Risk Corridor language for SFY 2017-18.	December 7, 2017 June 7, 2018 February 6, 2020
A–43 incorporates revises Hospital Quality Assurance Fee (HQAF) rates for January 1, 2017 to June 30, 2017.	August 1, 2019
A-44 incorporates full dual rates for Calendar Year (CY) 2017.	August 1, 2019
A-45 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019

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

Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010

A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) Ratification of rates requested April 7, 2016
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016
A–08 incorporates Adult & Family/Optional Targeted Low–Income Child and Adult Expansion rates for July 2016 to June 2017 and July 2017 to June 2018.	December 6, 2018

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017
A–02 extends the Agreement 16–93274 with DHCS to December 31, 2019	June 7, 2018
A–03 extends the Agreement 16–93274 with DHCS to December 31, 2020	May 2, 2019

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures	December 7, 2017

(P&Ps) to implement California Senate Bill (SB) 1004.	

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

MEDICARE-MEDICAID COORDINATION OFFICE

DATE: October 7, 2019

TO: Dual Eligible Special Needs Plans

FROM: Sharon Donovan

Director, Program Alignment Group

SUBJECT: CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs)

The Bipartisan Budget Act (BBA) of 2018 permanently authorized Dual Eligible Special Needs Plans (D-SNPs), strengthened Medicare-Medicaid integration requirements, and directed the establishment of procedures to unify Medicare and Medicaid grievance and appeals procedures to the extent feasible for D-SNPs beginning in 2021. On April 16, 2019, CMS finalized rules (hereafter referred to as the April 2019 final rule) to implement these new statutory provisions.[1] This memorandum summarizes the new requirements and provides guidance to D-SNPs on the contract and operational changes needed for each type of D-SNP beginning for Contract Year (CY) 2021.

Summary of New D-SNP Requirements

We summarize the D-SNP requirements CMS codified in the April 2019 final rule below.

Integration Requirements

Starting in CY 2021, D-SNPs must meet the new Medicare-Medicaid integration criteria in at least one of the following ways:

- By meeting the requirements to be designated as a fully integrated Dual Eligible SNP (FIDE SNP), as defined at 42 CFR 422.2. A FIDE SNP is offered by the legal entity that also has a state contract as a Medicaid managed care organization (MCO) to provide Medicaid benefits, including long-term services and supports (LTSS) and behavioral health benefits, consistent with state policy; or

- By meeting the requirements to be designated as a highly integrated D-SNP (HIDE SNP), as defined at 42 CFR 422.2. A HIDE SNP covers Medicaid LTSS and/or Medicaid behavioral health benefits, consistent with state policy, under a state contract either directly with the legal entity providing the D-SNP, with the parent organization of the D-SNP, or with a subsidiary owned and controlled by the parent organization of the D-SNP; or

- By having a contract with the state specifying a process to share information with the state, or the state's designee (such as a Medicaid MCO or an area agency on aging), on

[1] See CMS-4185-F, the "Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Programs of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-For-Service, and Medicaid Managed Care Programs for Years 2020 and 2021" final rule. Retrieved from https://www.govinfo.gov/content/pkg/FR-2019-04-16/pdf/2019-06822.pdf.

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hospital and skilled nursing facility (SNF) admissions for at least one group of high-risk individuals who are enrolled in the D-SNP, as provided at 42 CFR 422.107(d).

Unified Appeals and Grievances Processes

Certain D-SNPs and affiliated Medicaid managed care plans – specifically, those with "exclusively aligned enrollment" as described in more detail in the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this memorandum – must implement unified Medicare and Medicaid grievance and plan-level appeals processes starting in CY 2021. For these plans and their enrollees, implementation of the April 2019 final rule requirements will provide simpler, more straightforward grievance and appeals processes.

State Medicaid Agency Contract and Operational Changes

All D-SNPs must have executed contracts with applicable state Medicaid agencies, referred to as the "State Medicaid Agency Contract" (SMAC), as provided under section 1859(f)(3)(D) of the Social Security Act and 42 CFR 422.107. This section of the memorandum describes the SMAC and operational changes D-SNPs must implement to operate in CY 2021 and beyond. The first subsection describes requirements that apply to all D-SNPs. Subsequent subsections describe requirements that apply only to certain subsets of D-SNPs.

Requirements for all D-SNPs

D-SNPs are required to submit by the first Monday in July a SMAC to CMS for each state in which they seek to operate for the upcoming contract year. CY 2021 contracts must be submitted to CMS by July 6, 2020. Unlike in prior years, for CY 2021, D-SNPs with an evergreen SMAC will not be able to only submit letters of good standing with a previously executed SMAC from their respective states.

The April 2019 final rule modified several existing SMAC requirements that apply to all D-SNPs and added new requirements for some D-SNPs. To comply with these requirements for CY 2021, D-SNPs will need to work with state Medicaid agencies in advance of July 2020. (See the "Key Dates for D-SNPs" section of this memorandum for more information.) The table below highlights these changes to the minimum state contract elements.

The SMAC must document:
1. ***Revised:*** The D-SNP's: (1) responsibility to coordinate the delivery of Medicaid benefits; and (2) if applicable, responsibility to provide coverage of Medicaid services.
2. ***Revised:*** The category(ies) and criteria for eligibility for dually eligible individuals to be enrolled under the D-SNP (e.g., conditions of eligibility under Medicaid, such as nursing home level of care and age or requirement for D–SNP enrollees to enroll in a companion Medicaid plan to receive their Medicaid services).
3. ***Revised:*** The Medicaid benefits covered under a capitated contract between the state Medicaid agency and the MA organization offering the D-SNP, the D-SNP's parent organization, or another entity that is owned and controlled by the D-SNP's parent organization.
4. The cost-sharing protections covered under the D-SNP.
5. The identification and sharing of information on Medicaid provider participation.
6. The verification of enrollees' eligibility for both Medicare and Medicaid.
7. The service area covered by the D-SNP.

The SMAC must document:
8. The contract period for the D-SNP.
9. ***New:*** For a D-SNP that is not a FIDE SNP or HIDE SNP, a requirement for notification of hospital or SNF admissions for at least one designated group of "high risk" enrollees (see the "Information Sharing Requirements for all D-SNPs except FIDE SNPs and HIDE SNPs" section of this memorandum for more information).
10. ***New:*** For a D-SNP that is an applicable integrated plan, a requirement for the use of the unified appeals and grievance procedures (see the "Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment" section of this memorandum for more information).

In addition to the above contract requirements, 42 CFR 422.562(a)(5), codified in the April 2019 final rule and effective beginning 2020, requires that all D-SNPs assist their enrollees with Medicaid-related grievances and address access to care issues (such as filing appeals) as part of D-SNPs' responsibility to coordinate the delivery of Medicaid benefits in 42 CFR 422.2.

Information Sharing Requirements for All D-SNPs except FIDE SNPs and HIDE SNPs

As provided under 42 CFR 422.107(d), D-SNPs that do not contract with a state as FIDE SNPs or HIDE SNPs must include the additional minimum SMAC requirement to specify a process to share information on hospital and SNF admissions starting for CY 2021. For the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SMAC must describe:

- The process whereby the D-SNP notifies, or arranges for another entity or entities to notify, the state (and/or the state's designee) of hospital and SNF admissions for at least one group of high-risk full-benefit dually eligible individuals, identified by the state;
- The timeframe and methods by which such notice is provided; and
- The group(s) of high-risk full-benefit dually eligible individuals for whom the notice is provided.

The April 2019 final rule provides flexibility to the state on the parameters of the notification process, including:

- The manner in which notification occurs and how data is exchanged;
- The recipient(s) of the notification; and
- The group of high-risk full-benefit dually eligible individuals to which the notification applies, with no requirement on minimum size.

A state and a D-SNP may arrange for other entities to perform their respective obligations with respect to the notification. A state could contract with a D-SNP such that the D-SNP meets the notification requirement by arranging for another entity – such as a hospital – to notify the state or its designees when the various parties participate in a health information exchange (HIE) or other notification system

We encourage D-SNPs to engage with states and stakeholders as soon as possible to identify the most effective approaches and processes for this notification requirement. We note some existing resources for technical assistance and best practices at the end of this memorandum.

Requirements for All FIDE SNPs and HIDE SNPs

Beginning with CY2021, CMS is establishing a new procedure for identifying a D-SNP as a FIDE SNP or HIDE SNP when fully executed SMACs are submitted to CMS on the first Monday of July 2020. MA organizations seeking to offer FIDE SNPs and HIDE SNPs must request a CMS review of the SMAC so that CMS can confirm it complies with the contract requirements for FIDE SNPs and HIDE SNPs.

Unified Appeals and Grievance Requirements for FIDE SNPs and HIDE SNPs with Exclusively Aligned Enrollment

A subset of FIDE SNPs and HIDE SNPs with exclusively aligned enrollment must implement the unified appeals and grievance procedures described in 42 CFR 422.629 – 634 beginning in 2021. In the regulations, we refer to these plans as "applicable integrated plans," defined at 42 CFR 422.561 as FIDE SNPs or HIDE SNPs with exclusively aligned enrollment, where state policy limits the D-SNP's membership to a Medicaid managed care plan offered by the same organization. (In addition, the Medicaid MCO that covers Medicaid benefits for the dually eligible individuals in the FIDE SNP or HIDE SNP with exclusively aligned enrollment is also an applicable integrated plan subect to the unified appeals and grievance procedures under 42 CFR 438.210 and 438.402.) In such plans, one organization is responsible for managing Medicare and Medicaid benefits for all D-SNP enrollees.

SMACs for these plans must include provisions that the D-SNP uses the unified appeals and grievance procedures under 42 CFR 422.629 through 422.634, as well as conforming Medicaid managed care rules at 438.210, 438.400, and 438.402. The unified appeals process includes use of a specialized integrated denial notice (*see* 42 CFR 422.631(d)) for applicable integrated plans. CMS is developing a model of this and other appeals and grievance notices and will provide opportunities for comment before finalizing them.

As specified in the April 2019 final rule, states have the discretion to implement standards different than those established in the final rule if the state standards are more protective for enrollees, such as shorter timelines for a plan to make a decision on an appeal (*see* 42 CFR 422.629(c)). The SMAC must specify any requirements where the states use this discretion to implement standards different than those in 42 CFR 422.629 through 422.634, and D-SNPs must comply with any state-specific requirements in the SMAC. States may also need to make changes to Medicaid MCO contracts for the applicable integrated plans to specify the additional requirements for unified grievances and appeals from 42 CFR 422.629 through 422.634, 438.210, 438.400, and 438.402.

Intermediate Sanctions

As provided in 42 CFR 422.752, for any D-SNP not meeting the integration criteria listed in this memorandum and specified at 42 CFR 422.2, CMS will impose, during plan years 2021 through 2025, intermediate sanctions specified at 42 CFR 422.750(a). CMS will impose intermediate sanctions specifically where CMS determines that a D-SNP fails to meet at least one of the criteria for the integration of Medicare and Medicaid benefits provided in the definition of a D-SNP at 42 CFR 422.2 and specified above.

Key Dates for D-SNPs

All D-SNPs are required to submit a new SMAC (or an evergreen SMAC with a contract addendum) to CMS for each state in which they seek to operate in for CY 2021 by Monday July 6, 2020. This includes, as applicable, the new contract requirements codified in 42 CFR 422.107(c) and (d) and summarized in this memorandum. **Therefore, we strongly encourage**

states and D-SNPs to begin discussing SMAC updates as soon as possible. The table below provides key dates and activities for states and D-SNPs related to compliance with the new requirements.

Month/Year	Activity
Fall 2019	• States and D-SNPs begin drafting changes needed to ensure SMAC meets new requirement • States plan for any needed MCO contract changes
Winter 2020	• States and D-SNPs identify and create any new policies and procedures needed in response to contract changes
January 2020	• CMS releases Contract Year 2021 MA (SNP) applications
February 2020	• SNP applications (including SNP service area expansion applications) due to CMS
Spring 2020	• States and D-SNPs finalize SMACs
June 2020	• D-SNPs not renewing MA contracts notify CMS in writing • Bid submission deadline
July 2020	• D-SNPs submit SMAC and related documents to CMS by Monday July 6, 2020
July/August 2020	• D-SNPs work with CMS and states to address deficiencies in SMACs
Summer 2020 - Fall 2020	• States and D-SNPs finalize policies and procedures for CY 2021
August/September 2020	• CMS issues SMAC status review letters and, as applicable, intermediate sanction letters • D-SNPs send Annual Notice of Change and Evidence of Coverage (including information about any changes to grievances and appeals procedures for applicable integrated plans) to current enrollees
January 1, 2021	• Effective date for most April 2019 final rule provisions

Resources

The CMS Medicare-Medicaid Coordination Office (MMCO) works across CMS and with states to better serve dually eligible individuals, including through efforts to better align the Medicare and Medicaid programs through integrated service delivery under D-SNPs. We are providing technical assistance to states to help with implementation of these new requirements through the Integrated Care Resource Center (ICRC). We believe the information for states will also be helpful to D-SNPs as they update SMACs to meet the requirements detailed in this memorandum.

Listed below are currently available resources.

- **Update on State Contracting with D-SNPs: The Basics and Meeting New Federal Requirements for 2021** (https://www.integratedcareresourcecenter.com/webinar/update-state-contracting-d-

snps-basics-and-meeting-new-federal-requirements-2021) provides an overview of state strategies for contracting with D-SNPs to improve care coordination and Medicare-Medicaid alignment for dually eligible enrollees. Special attention is given to new federal D-SNP integration standards for 2021 contract year, and how states can help plans to meet these requirements.

- **Promoting Information Sharing by Dual Eligible Special Needs Plans to Improve Care Transitions: State Options and Considerations** (https://www.integratedcareresourcecenter.com/resource/promoting-information-sharing-dual-eligible-special-needs-plans-improve-care-transitions) examines the approaches used by three states to develop and implement information-sharing processes for their D-SNPs that support care transitions. The brief includes examples of contract language and strategies to encourage plan collaboration and problem solving around information sharing. It can help states, D-SNPs, and other stakeholders assess how to meet the new D-SNP contracting requirements and improve the care of dually eligible individuals.

- **Information Sharing to Improve Care Coordination for High-Risk Dual Eligible Special Needs Plans Enrollees: Key Questions for State Implementation** https://www.integratedcareresourcecenter.com/resource/information-sharing-improve-care-coordination-high-risk-dual-eligible-special-needs-plan) offers key questions and considerations that states can review as they begin working with D-SNPs and other parties to design and implement information-sharing requirements. This technical assistance tool includes sample contract language.

Additionally, we expect ICRC to develop and disseminate sample contract language that both state and D-SNPs can use to develop their SMACs.

More Information

For any questions about the contents of this memorandum, D-SNPs should contact their account manager.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Approval of CalOptima Policy and Procedure GG.1352 Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21

Contacts

David Ramirez, M.D., Chief Medical Officer (714) 246-8400
Tracy Hitzeman, R.N., Executive Director, Clinical Operations (714) 246-8400

Recommended Action

Approve CalOptima Policy and Procedure, GG.1352: Private Duty Nursing Care Management of Medi-Cal Eligible Members under the Age of 21 consistent with state requirements.

Background

CalOptima is obligated to ensure that assigned members have access to all medically necessary Medi-Cal covered services except for those services that are carved out of CalOptima's contract with the Department of Health Care Services (DHCS). Case management is provided to coordinate the provision of services, including those services that are carved out from CalOptima's Medi-Cal contract with DHCS.

Under the Early and Periodic Screening, Testing, Diagnosis and Treatment (EPSDT) guidelines, Private Duty Nursing (PDN) may be medically necessary for members under age 21, and PDN services may be provided in a member's home by a registered nurse (RN) or a licensed vocational nurse (LVN), under the direction of a physician when the member needs more continuous care than what a home health visiting nurse can typically provide.

Discussion

DHCS recently issued guidance to clarify managed care health plan case management responsibilities for members under age 21 who have been approved for PDN services under the EPSDT benefit, which include:

- Providing the member with information about the number of PDN hours that have been approved as well as the case management services available
- Working with enrolled PDN providers to arrange for approved services
- Assisting potentially eligible PDN providers with Medi-Cal provider enrollment

CalOptima Policy GG.1352 ***Private Duty Nursing Care Management*** has been developed to communicate the requirements of DHCS's guidance and how this benefit will be operationalized.

Fiscal Impact

The recommended action to approve CalOptima Policy GG.1352 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

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Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the presented CalOptima policy and procedure.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Policy GG.1352 Private Duty Nursing Care Management
2. DHCS All Plan Letter 20-012 Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age Of 21

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

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Policy:	GG.1352
Title:	**Private Duty Nursing Care Management**
Department:	Medical Management
Section:	Case Management
CEO Approval:	
Effective Date:	
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the scope of the provision of case management services for Private Duty Nursing (PDN) services for CalOptima Medi-Cal Members under the age of twenty-one (21) years.

II. POLICY

A. CalOptima and its Health Networks shall provide appropriate preventive, mental health, developmental, and specialty Early and Periodic Screening, Diagnosis, and Treatment medical services, including PDN services, under the scope of the CalOptima program to eligible Members under the age of twenty-one (21) years in accordance with applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance, and CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services**.**

B. CalOptima or a Health Network shall provide case management services for eligible Members with approved PDN services under the EPSDT benefit or under the California Children's Services (CCS)/Whole-Child Model.

C. Upon a Member's request, CalOptima or a Health Network shall provide case management services to arrange for all authorized PDN service hours for its eligible Members even if not financially responsible for the PDN services.

D. CalOptima or a Health Network shall use one (1) or more Medi-Cal-enrolled Home Health Agencies (HHA) or Individual Nurse Providers (INP) to meet a Member's approved PDN service needs.

E. CalOptima shall issue a notice to every Member under the age of twenty-one (21) years for whom it has currently authorized PDN services on or before July 31, 2020. The notice will explain:

1. CalOptima's primary responsibility for case management of PDN services;

2. Describe case management services;

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3. How to access case management services;

4. How to utilize CalOptima's grievance and appeal process to address difficulties in receiving PDN services or dissatisfaction with case management services;

5. How to file a Medi-Cal fair hearing, or email DHCS directly at EPSDT@dhcs.ca.gov; and

6. The number for Disability Rights California at (888) 852-9241 for questions about Member legal rights regarding PDN services.

III. PROCEDURE

A. CalOptima or a Health Network shall authorize Medically Necessary PDN services in accordance with CalOptima Policy GG.1121: Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and GG.1508: Authorization and Processing of Referrals

B. Upon authorization of PDN services, CalOptima or a Health Network shall:

1. Notify the Member of the number of PDN hours the Member is approved to receive;

2. Arrange for approved PDN services on behalf of the Member with enrolled HHAs or INPs;

3. For Members enrolled in CalOptima Direct or CalOptima Community Network, generate a referral for care management in accordance with CalOptima Polices GG.1121: Early and Periodic Screening and Diagnostic Treatment (EPSDT) Services and CalOptima Policy GG.1301: Complex Case Management Process.

4. A case manager shall assist the Member with coordination of PDN services, including working with HHAs or INPs to jointly provide PDN services to the Member, if necessary, and collaborating with other entities as appropriate.

5. A case manager shall identify potentially eligible HHAs and INPs and assist them with navigating the process of enrolling to become Medi-Cal providers.

C. A Member may choose not to use all approved PDN service hours. CalOptima and its Health Network must respect this choice.

D. CalOptima or a Health Network shall document and report instances when a Member chooses not to use approved PDN services as required by DHCS. A Health Network shall report such instances to the CalOptima Case Management Department in a manner and frequency requested by CalOptima.

E. CalOptima or a Health Network shall document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Health Network Service Agreement
C. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-012: Private Duty Nursing Case Management Responsibilities for Medi-Cal Eligible Members Under the Age Of 21

D. CalOptima Policy GG.1121: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services
E. CalOptima Policy GG.1301: Complex Case Management Process
F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
H. 42 Code of Federal Regulations §§440.80, 441.18 and 440.169
I. 22 California Code of Regulations §§51184(d), (g)(5) and (h)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective		GG.1352	Private Duty Nursing Care Management	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
Case Management	Those services furnished to assist individuals eligible under the Medi-Cal State plan who reside in a community setting or are transitioning to a community setting, in gaining access to needed medical, social, education, and other services in accordance with 42 Code of Federal Regulations (CFR) sections 441.18 and 440.169.
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	A comprehensive and preventive child health program for individuals under the age of twenty-one (21) years. EPSDT is defined by law in the Federal Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing services. In addition, section 1905(r)(5) of the Federal Social Security Act (the Act) requires that any Medically Necessary health care service listed in section 1905(a) of the Act be provided to an EPSDT recipient even if the service is not available under the State's Medicaid plan to the rest of the Medicaid population.
Home Health Agency	For purposes of this Policy, as defined in Health and Safety Code section 1727(a) and used herein, means a public or private organization licensed by the State which provides skilled nursing services as defined in Health and Safety Code section 1727(b), to persons in their place of residence.
Individual Nurse Providers (INP)	A Medi-Cal enrolled registered nurse (RN) or licensed vocational nurse (LVN) who independently provides Private Duty Nursing services in the home to Medi-Cal beneficiaries.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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.
Private Duty Nursing	Nursing services provided in a Member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a Member who requires more individual and continuous care than what would be available from a visiting nurse.

Term	Definition
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified 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.

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: May 15, 2020

ALL PLAN LETTER 20-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: Private Duty Nursing Case Management Responsibilities For Medi-Cal Eligible Members Under The Age Of 21

PURPOSE:
The purpose of this All Plan Letter (APL) is to clarify Medi-Cal managed care health plan (MCP) obligations related to the provision of case management services for Private Duty Nursing (PDN) services that have been approved for members under the age of 21 pursuant to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit.

BACKGROUND:
EPSDT is a Medi-Cal benefit that provides a comprehensive array of preventive, diagnostic, and treatment services, including but not limited to case management, for individuals under the age of 21, as set forth in the Social Security Act (SSA), section 1905(r) and Title 42 of the United States Code (USC), section 1396d(r).[1, 2] In California, the EPSDT benefit is established in Welfare and Institutions Code (WIC).[3, 4]

MCPs are generally required to provide and cover all medically necessary Medi-Cal covered services, other than those services carved out of the MCP contract with the Department of Health Care Services (DHCS). Even for carved-out services, MCPs are responsible for providing case management to ensure the provision of medically necessary services, whether those services are delivered within or outside of the MCP's provider network. State law provides that for individuals under 21 years of age, a service is medically necessary or a medical necessity if it meets the standards set forth in 42

[1] SSA, section 1905 is available at: https://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[2] 42 USC, section 1396d is available at: http://uscode.house.gov/view.xhtml?req=(title:42%20section:1396d%20edition:prelim
[3] See WIC section 14132(v), available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.&lawCode=WIC
[4] For more information regarding EPSDT, see APL 19-010, "Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21," or any superseding APL. APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx.

USC, section 1396d(r)(5).[5] Comprehensive case management for medically necessary services, including both basic and complex case management, is described in MCP contracts.[6] Further, the MCP contracts set forth requirements for Services for Children with Special Health Care Needs, which include case management and coordination of care.[7]

For some MCP members under age 21, PDN services may be medically necessary. PDN services are nursing services provided in a member's home by a registered nurse (RN) or licensed vocational nurse (LVN) for a member who requires more individual and continuous care than what would be available from a visiting nurse.[8] RNs and LVNs providing PDN services to MCP members must either be Medi-Cal enrolled as individual providers who offer PDN services independently, or they may offer services through a Medi-Cal enrolled home health agency (HHA).[9] An HHA is a state-licensed public or private organization that provides in-home skilled nursing services.[10]

In some cases, MCPs authorize PDN services. In other cases, an MCP member may be approved to receive PDN services through a program outside of Medi-Cal managed care, such as California Children's Services (CCS) or Medi-Cal fee-for-service. For plans

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[5] See WIC section 14059.5(b), stating, "(1) For individuals under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the standards set forth in Section 1396d(r)(5) of Title 42 of the United States Code. (2) The department and its contractors shall update any model evidence of coverage documents, beneficiary handbooks, and related material to ensure the medical necessity standard for coverage for individuals under 21 years of age is accurately reflected in all materials." See also 42 USC, section 1396d(r)(5) "Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the State plan."
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14059.5.&lawCode=WIC

[6] MCP Contracts, Exhibit A, Attachment 11. MCP boilerplate contracts are available at:
https://www.dhcs.ca.gov/provgovpart/Pages/MMCDBoilerplateContracts.aspx

[7] MCP Contracts, Exhibit A, Attachment 11.

[8] See Title 42 of the Code of Federal Regulations, section 440.80, available at:
https://www.ecfr.gov/cgi-bin/text-idx?SID=2888566bb0df8b362250dc4c2a3311ab&mc=true&node=pt42.4.440&rgn=div5#se42.4.440_180

[9] For more information about provider enrollment, see APL 19-004, "Provider Credentialing / Recredentialing and Screening / Enrollment," or any superseding APL.

[10] See Health and Safety Code section 1727, available at:
http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1727.&lawCode=HSC

participating in the CCS Whole Child Model program, there is no carve-out of PDN services for CCS eligible conditions, and the MCP authorizes PDN services for both CCS covered conditions and under EPSDT.

POLICY:
MCPs are contractually obligated to provide case management services to members. Specifically, for Medi-Cal eligible members under the age of 21 who have had PDN services approved, MCPs are required to provide case management, as set forth in the MCP contract, and to arrange for all approved PDN services, whether or not the MCP is financially responsible for the PDN services.[11]

If the MCP is the entity that approved the PDN services for an eligible member under the age of 21, the MCP is primarily responsible for providing case management to arrange for all approved PDN service hours. If another entity, such as CCS, has authorized PDN services and is primarily responsible for providing case management for those PDN services, MCPs must still provide case management as necessary, including, at the member's request, arranging for all approved PDN services. MCPs must use one or more Medi-Cal enrolled HHAs or individual nurse providers, or any combination thereof, to meet the member's approved PDN service needs.

PDN Case Management Responsibilities
When an eligible member under the age of 21 is approved for PDN services and requests that the MCP provide case management services for those PDN services, the MCP obligations include, but are not limited to:

- Providing the member with information about the number of PDN hours the member is approved to receive;
- Contacting enrolled HHAs and enrolled individual nurse providers to seek approved PDN services on behalf of the member;
- Identifying potentially eligible HHAs and individual nurse providers and assisting them with navigating the process of enrolling to become a Medi-Cal provider; and
- Working with enrolled HHAs and enrolled individual nurse providers to jointly provide PDN services to the member.

Members may choose not to use all approved PDN service hours, and MCPs are permitted to respect the member's choice. MCPs must document instances when a member chooses not to use approved PDN services. When arranging for the member to

[11] Acceptance of available PDN services is at the member's discretion. Members are not required to use all approved PDN service hours.

receive authorized PDN services, MCPs must document all efforts to locate and collaborate with providers of PDN services and with other entities, such as CCS.

Policies and Procedures

MCPs are required to issue new or revised policies and procedures that comply with the requirements of this APL. Within 90 days of the release of this APL, MCPs must submit copies of the new or updated policies and procedures to their Managed Care Operations Division (MCOD) Contract Manager for review and approval.

Notice to Members

The MCP is required to issue a notice to every member under the age of 21 for whom it has currently authorized PDN services on or before July 31, 2020. The notice must:

- Explain that the MCP has primary responsibility for case management of PDN services.
- Describe the case management services available to the member in connection with PDN services, as set forth above.
- Explain how to access those services.
- Include a statement that the member may:
    - Utilize the MCP's existing grievance and appeal procedures to address difficulties in receiving PDN services or their dissatisfaction with their case management services;
    - File a Medi-Cal fair hearing as provided by law; or
    - Email DHCS directly at EPSDT@dhcs.ca.gov.
- Include a statement that if the member has questions about their legal rights regarding PDN services, they may contact Disability Rights California at (888) 852-9241.

Monitoring & Oversight

DHCS will audit MCP compliance with the PDN services case management policy outlined in this APL and the case management requirements set forth in the MCP's contract with DHCS. If the MCP fails to comply with the requirements of this APL or the case management requirements in the MCP's contract, DHCS may require a corrective action plan and/or assess monetary penalties as provided for in the MCP contract and any applicable state or federal statutes and regulations.[12]

[12] For more information on corrective action, see APL 18-003, "Administrative and Financial Sanctions," or any superseding APL.

MCPs are responsible for ensuring that their subcontractors and network providers comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Policy Letters. These requirements must be communicated by each MCP to all subcontractors and network providers.

If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
6. Consider Approval of Modifications to CalOptima's Medical Policies and Procedures

Contact
David Ramirez, M.D., Chief Medical Officer (714) 246-8400
Tracy Hitzeman, Executive Director, Clinical Operations (714) 246-8400

Recommended Action(s)
Authorize the Chief Executive Officer (CEO) to modify the following existing medical policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. Policy GG.1503 CalOptima Hospice Coverage, Notification and Validation Requirements
2. Policy GG.1808: Plan of Care, Long Term Care

Background/Discussion
CalOptima regularly reviews its Policies and Procedures to ensure they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws as well as CalOptima operations.

Below is information regarding the policies that require modification:

1. **Policy GG.1503** ***CalOptima Hospice Coverage, Notification and Validation Requirements*** describes CalOptima's hospice benefit coverage, Notification and Validation requirements. Hospice Routine Home Care, Continuous Home Care and Respite Care do not require prior authorization from CalOptima or the Health Network. However, the hospice agency must notify CalOptima or the Health Network of the initiation of services for each certification period and provide documentation including a Certification of Terminal illness. Documentation of service intensity for validation of Continuous Home Care and Respite Care is required. General Inpatient Care requires prior authorization. CalOptima staff has updated to improve clarity of the policy, aligning with the Health Network-specific Division of Financial Responsibilities (DOFR), adding requirements and references for Members receiving services under the Whole Child Model (WCM) program and including timeframes for Notification/Validation.

2. **Policy GG.1808.** ***Plan of Care, Long Term Care*** delineates requirements for an individually written Plan of Care for Members admitted to a Long Term Care (LTC) facility, including a Skilled Nursing Facility for Nursing Facility (NF-A), Nursing Facility (NF-B) Level of Care, and Subacute Facility -Adult/Pediatric, and to ensure CalOptima Members receive coordinated care across the continuum of services, including medical, behavioral health and long term services and supports. CalOptima staff updated this policy removing a description of discharge activities that are described

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in CalOptima Policy GG.1822: Process for Transitioning CalOptima Members between Levels of Care, instead referencing the existing policy.

Fiscal Impact

The recommended action to revise CalOptima Policies GG.1503 and GG.1808 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede the prior version.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Policy GG.1503 CalOptima Hospice Coverage, Notification and Validation Requirements (Redlined and Clean versions)
2. CalOptima Policy GG.1808. Plan of Care, Long Term Care (Redlined and Clean versions)

/s/ Richard Sanchez — *07/29/2020*

Authorized Signature — **Date**

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Policy:	GG.1503
Title:	**CalOptima Hospice Coverage, Notification and Validation Requirements**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	
Effective Date:	06/01/2001
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

To clarify CalOptima's hospice benefit coverage, ~~notification~~Notification and ~~validation~~Validation requirements.

II. POLICY

A. CalOptima and its Health Networks shall be responsible for ensuring the provision of Hospice Care services for Terminally Ill Members who meet the requirements outlined in Section II.~~F~~C of this policy. CalOptima ~~or~~and its Health ~~Network~~Networks shall be responsible for~~:~~ the following, in accordance with Health Network-specific Division of Financial Responsibilities (DOFR):

~~1. Hospice Care services for a Member who receives services under the California Children's Services (CCS) program who elects Hospice care benefits. Members shall continue to receive medically necessary treatment services for other CCS-eligible conditions through the CCS program in accordance with CalOptima Policy GG.1101: California Children's Services; and~~

~~2. Room and Board coverage for a Member residing in a Long Term Care (LTC) facility and receiving Hospice Care services.~~

~~3.~~1. The following Hospice Care services as determined by the Member's enrollment in a CalOptima program:

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CalOptima Program	CalOptima Hospice Care Services Responsibility				
	Routine Home Hospice (Rev Code 651)	**Continuous Home Care (Rev Code 652)**	**Respite Care (Rev Code 655)**	**General Inpatient Care (Rev Code 656)**	**SNF: Room and Board (Rev Code 658)**
Medi-Cal	Yes	Yes	Yes	Yes	Yes
OneCare	No*	No*	No*	No*	Yes
OneCare Connect	No*	No*	No*	No*	Yes
CalOptima Direct – Administrative (COD-A) Dual eligible ~~Member~~member	No*	No*	No*	No*	Yes
*Billed to Medicare Fee-For-Service/Original Medicare.					

2. A Member who receives services under the Whole Child Model (WCM) program who elects Hospice Care services shall continue to receive Medically Necessary treatment services for any other California Children's Services (CCS)-eligible Conditions; and

3. Room and Board coverage for a Member residing in a Long-Term Care (LTC) facility through the Medi-Cal benefit and receiving Hospice Care services.

B. Medicare Hospice Benefit Eligibility Requirements:

1. Medicare Part A (Hospital Insurance) coverage;

2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease runs its normal course);

3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and

4. The Member or Authorized Representative signs a statement choosing ~~hospice care~~Hospice Care instead of other Medicare-covered treatments for the Terminal Illness and related conditions.

~~5. The Member may still receive medical services not related to the Terminal Illness through Medicare Part A or a Medicare health plan.~~

C. Medi-Cal Hospice Benefit Eligibility Requirements:

1. Medi-Cal is the Member's primary inpatient/hospital coverage;

2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease is to run its normal course);

3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and

4. The Member or Authorized Representative signs a statement choosing ~~hospice care~~Hospice Care instead of other Medi-Cal covered treatments for the Terminal Illness and related conditions.

5. A Member younger than twenty-one (21) years of age, and certified by a physician as having a life expectancy of six (6) months or less, may elect to concurrently receive hospice services and palliative care in addition to curative treatment of the hospice-related diagnosis in accordance with CalOptima Policy GG.1550: Palliative Care Services.

D. A Member may elect to receive hospice benefits for two (2) election periods consisting of ninety (90) calendar days each and an unlimited number of subsequent periods of sixty (60) calendar days each. At any time during an election period, a Member may elect to revoke or modify ~~hospice care~~Hospice Care. A Member or Member's Authorized Representative must file a signed statement with the Hospice Provider revoking the Member election for the remainder of the election period. A change from one designated Hospice Provider to another is not considered a revocation of the hospice election.

E. Four (4) levels of Hospice Care:

1. Routine Home Care;

2. Continuous Home Care;

3. Respite Care; and

4. General Inpatient Care.

F. Notification and Validation Requirements

1. A Member with Medicare A and B coverage living in the community (not in ~~a~~an LTC facility) shall be exempt from all ~~notification~~Notification requirements related to coverage of

professional services for hospice. ~~LTC facility service requests shall follow the Hospice Notification/Validation requirements. The Hospice Provider shall notify and coordinate with CalOptima for healthcare services unrelated to the Terminal Illness.~~

2. For OneCare Connect, OneCare, and Medi-Cal primary Members, the Hospice Provider shall notify and coordinate with CalOptima or the Member's assigned Health Network for covered healthcare services that are unrelated to the Terminal Illness.

~~2.~~3. Medi-Cal primary Members may access ~~hospice care~~Hospice Care within twenty-four (24) hours of ~~the~~ Notification of Hospice request. CalOptima shall not require ~~Prior Authorization~~prior authorization for Hospice Care services under Routine Home Care, Continuous Home Care, and Respite Care ~~Levels~~levels of ~~hospice care~~Hospice Care. A Hospice Provider shall provide documentation to support these levels of care.

Level of Care	**Notification**	**Validation**
Routine Home Care	Notification Required – within thirty (30) calendar days of start of service.	Required for each certification period – two (2) ninety (90) calendar day periods, then unlimited 60 calendar day periods. Certification of Terminal Illness documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate the Member has received a minimum of eight (8) hours of direct care within a twenty-four (24)-hour period.
Respite Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate that Member received Respite Care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five (5) consecutive days at a time.
General Inpatient Care	Authorization Required. Notification required within one (1) business day but no more than seven (7) calendar days of start of service.	Required – authorization will be granted in seven (7) day intervals upon Validation of medical needs justification
Service Intensity Add-on	Notification required within twenty-four (24) hours after Member's death	Submit documentation to validate the Member has received service provided by a Social Worker or Registered Nurse during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days
Special Physician Services	Notification required within thirty (30) calendar days of start of service	Submit documentation to validate the Member has received services provided by a physician specializing in services that meets the Member's specific needs, and the hospice employed physician is unable to meet the Member's needs, and limited to one (1) visit per day per Member

~~3.~~4. For Medi-Cal primary Members requiring General Inpatient Care, planned or unplanned admissions, a Hospice Provider shall submit an authorization request for ~~Hospice~~hospice

services within the next business day or no later than seven (7) calendar days after the start of services. If a ~~Hospice Provider~~hospice provider does not provide adequate clinical documentation or documents do not substantiate the need for General Inpatient Care, the CalOptima Medical Director may reduce the ~~level~~Level of ~~care~~Care to Routine Home Care. Following such a decision, the Hospice Provider shall have the right to appeal the ~~level~~Level of ~~care~~Care decision, in accordance with CalOptima Policies GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~ and GG.1814: Appeal Process for Long-Term Care Facility ~~Daily Rate Denial, Modification, or Recommendation~~.

5. Notification for Routine Home Care during the last seven (7) days of life – Service Intensity Add-On (SIA)

a. If a Medi-Cal primary Member was determined to be in the last seven (7) days of life, the Hospice Provider shall notify CalOptima within twenty-four (24) hours of Member's expiration and request SIA when the following criteria are met:

i. The day was a Routine Home Care Level of Care day;

ii. The days occurred during the last seven (7) days of life and the Member expired;

iii. The service was provided in-person by a Social Worker or a Registered Nurse; and

iv. The SIA number of hours (in fifteen (15) minute increments) of service provided by a Registered Nurse or Social Worker during the last seven (7) days of life met a minimum of fifteen (15) minutes and a maximum of four (4) hours per day, up to seven (7) days, not to exceed a combined maximum of 112 units.

~~4.~~6. If a CalOptima Member, regardless of CalOptima program enrollment, utilizes Hospice Care services in a LTC facility, the Hospice Provider shall submit ~~notification~~Notification for facility services (room and board) to the CalOptima Long Term Services and Supports (LTSS) Department.

a. The Hospice Provider shall submit a ~~notification~~Notification for hospice services for a CalOptima Medi-Cal Member within thirty (30) calendar days after the start of services for the following Hospice ~~level~~Level of ~~care~~Care services utilizing the Hospice Validation / Notification ~~form~~Form (HVNF) to include the dates of service along with documentation of services provided:

i. Continuous Home Care;

ii. Routine Home Care;

iii. Respite Care; and

iv. Special ~~Physician Services~~physician services.

~~5.1. Notification for Routine Home Care during the last seven (7) days of life – Service Intensity Add-On (SIA)~~

a. If a Medi-Cal Member has been determined to be in the last seven (7) days of life, the Hospice Provider shall notify CalOptima within twenty-four (24) hours of Member's expiration and request notification for services when the following criteria are met:

i. The day is a Routine Home Care level of care day;

ii. The days occur during the last seven (7) days of life (and the Member is discharged expired);

iii. The service is to be provided in person by a Social Worker or a Registered Nurse; and

iv. The SIA amount shall equal the number of hours (in 15 minute increments) of service provided by a Registered Nurse or Social Worker during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day, up to seven (7) days, not to exceed a combined maximum of one hundred twelve (112) units.

6. A Hospice Provider shall submit notification for facility services for a Health Network Member, in accordance with the Health Network's policy.

7. Facility service (room and board) requests for CalOptima Members shall follow the Hospice Notification/Validation requirements.

Level of Care	Notification	Validation
Routine Home Care	Notification Required – within thirty (30) calendar days of start of service.	Required for each certification period – two (2) ninety (90) calendar day periods, then unlimited sixty (60) calendar day periods. Certification documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate the Member has received a minimum of eight (8) hours of direct care within a twenty-four (24) hour period.

If a Medi-Cal primaryRespite Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate that Member received Respite Care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five (5) consecutive days at a time.
General Inpatient Care	Authorization Required. Notification required within one (1) business day but no more than seven (7) calendar days of start of service.	Required – authorization will be granted in seven (7) day intervals upon validation of medical needs justification

~~Service Intensity Add-on Social Worker~~	~~Notification required within twenty four (24) hours after Member's death~~	~~Submit documentation to validate the Member has received service provided by a Social Worker during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days~~
~~Service Intensity Add-on Registered Nurse~~	~~Notification required within twenty four (24) hours after Member's death~~	~~Submit documentation to validate the Member has received service provided by a Registered Nurse during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days~~
~~Special Physician Services~~	~~Notification required within thirty (30) calendar days of start of service~~	~~Submit documentation to validate the Member has received services provided by a physician specializing in services that meets the Member's specific needs, and the hospice employed physician is unable to meet the Member's needs, and limited to one (1) visit per day~~

~~G. Hospice Care Services~~

~~1. CalOptima or a Health Network may require that a Medi-Cal Member uses a contracted Hospice Provider. A Medi-Cal Member receiving Hospice Care services from a non-contracted Hospice Provider at the time the Member becomes enrolled in a Health Network shall remain with such non-contracted Hospice provider until the Member can be transitioned to a contracted Hospice provider during a new hospice election period.~~

~~H.~~G. ~~If the~~ Member requests to change a Hospice Provider, the current Hospice Provider shall provide a transferring Member with a transfer summary signed by the Member's ~~Hospice~~hospice physician. The transfer summary shall include, but not be limited to the following information:

1. Member's diagnosis;
2. Pain treatment, and management;
3. Medications;
4. Medical treatments;
5. Dietary requirement;

6. Known allergies;

7. Treatment plan; and

8. Previous hospice benefit period information.

~~I.~~H. A Member who moves his or her legal residence outside of Orange County must disenroll from CalOptima. ~~-~~Hospice ~~providers~~Providers shall provide transferring Members with a transfer summary which shall be signed by the physician. Upon enrollment in ~~a~~the new ~~Medi-Cal managed care plan~~county, a "change in designated hospice" must be initiated. This may be done only once per election period.

~~J.~~I. CalOptima and ~~a~~its Health ~~Network~~Networks, in accordance with the active DOFR, shall pay the standard per diem set by ~~Medicare or~~ Medi-Cal to all Hospice Providers~~.~~ for Medi-Cal primary Members. For a Member who has Medicare and Medi-Cal residing in ~~a~~an LTC facility, the Hospice Provider shall bill Medicare for the hospice services and bill CalOptima for room and board. ~~The total reimbursed amount shall not exceed the Medicare rate.~~

~~K.~~J. CalOptima ~~or a~~and its Health ~~Network~~Networks, in accordance with the active DOFR, shall pay two (2) different Routine Home Care rates for Medi-Cal primary Members, based upon the following:

1. Routine Home Care high rate: defined as day one (1) to sixty (60) of an episode; and

2. Routine Home Care low rate: defined as day sixty~~-~~one (61) and beyond.

3. For a Member who is discharged and readmitted to hospice within sixty (60) calendar days of that discharge, the Member's hospice days will continue to follow the patient and count toward the Member days for the receiving hospice in the determination of whether the receiving Hospice Provider may be considered at the high or low Routine Home Care rate, upon hospice election.

4. For a Member who has been discharged from Hospice Care for more than sixty (60) calendar days, a new election to Hospice will initiate a reset of the Member's sixty (60) calendar day window and it is considered at the Routine Home Care high rate upon the new Hospice election.

~~L.~~K. Special Physician Services for Medi-Cal primary Members

1. A Hospice Provider shall submit a ~~notification~~Notification with medical justification including diagnoses related to the ~~Member's~~Member's Terminal Illness. ~~-~~CalOptima shall review and make medical determination for requests for ~~physician services~~Special Physician Services for pain and symptom management based on medical justification. The Special Physician Services shall not be provided by the ~~Member's~~Member's Hospice attending physician and requires~~;~~:

   a. Immediate need; and

   b. The Hospice attending physician does not have the required special skills.

2. Special Physician Services is limited to one (1) visit-per-day, per Member.

~~M.~~L. CalOptima and its Health Networks, in accordance with the Health Network-specific DOFR, are responsible for the provision of all Medically Necessary Covered Services not related to a Member's Terminal Illness , including ~~Covered Services~~covered services provided by a Member's Primary Care Provider (PCP).

~~N.~~M. CalOptima ~~and~~or its Health ~~Networks shall~~Network, in accordance with the active DOFR, may provide ongoing care coordination to a OneCare Connect, OneCare, or Medi-Cal primary Member receiving Hospice Care to ensure that services necessary to diagnose, treat, and follow-up on conditions not related to the Terminal Illness continue to be provided, or are initiated, as necessary.

N. The Member may still receive medical services not related to the Terminal Illness through Medicare Part A and B or a Medicare health plan.

O. CalOptima shall not approve any claims requests submitted after one (1) year from the date of service.

P. For exceptional circumstances, Hospice Providers that submit a claim after twelve (12) months from the month of service shall provide acceptable documentation justifying the reason for delay. Acceptable documentation may include:

1. Court decisions;
2. Fair hearing decisions;
3. County administrative errors in determining Member eligibility;
4. Reversal of decisions on appealed Authorization Request Form (ARF);
5. Medicare/Other Health coverage delays; or
6. Other circumstances beyond the Hospice ~~provider's~~Provider's control (i.e~~.~~., natural disasters).

Q. CalOptima shall ensure for any authorizations ~~that are required~~for which it is responsible, for Hospice Care services ~~is~~under the Medi-Cal benefit, are consistently applied to medical/surgical, mental health, and substance use disorder services.

III. PROCEDURE

A. CalOptima ~~and~~or its Health Networks, in accordance with the Health Network-specific DOFR, shall be responsible for providing Hospice Care to a Medi-Cal primary Member if the following criteria are validated:

1. The physician ~~requests Hospice Care services for a Member; and~~has executed a certification of Terminal Illness that complies with 42 CFR §418.22.

~~2. The Member is Terminally Ill; and~~

~~3. The Hospice Provider evaluates the Member and determines that the Member meets the criteria for Hospice Care services; and~~

4.2. The Notice of Election or Revocation Statement is signed by the Member or Member's Authorized Representative. The following must be included on the form:

a. Identification of the Hospice Provider;

b. The Member's or the Member's Authorized Representative's acknowledgement that he or she has full understanding that the Hospice Care services given as related to the Member's Terminal Illness will be palliative, rather than curative in nature, unless the Member is a child under twenty-one (21) years of age, and that certain specified Medi-Cal benefits are waived by the election;

c. The effective date of election; and

d. The signature of the Member or the Member's Authorized Representative.

B. A Hospice Provider shall be responsible for services related to the Member's Terminal Illness, including, but not limited to, pharmacy, physician, social services, nursing, home health aide services, home maker services, Durable Medical Equipment (DME), supplies, multi-disciplinary hospice services, hospice physician consultation for patients, dietary or nutritional counseling, bereavement, and grief and spiritual counseling.

C. For a Member residing in aan LTC facility, reimbursement will follow the Level of Care table below::

Level of Care	Service Location	Payment
Routine Home Care	Private home, residential care facility, board and care or nursing facility A or B level.	Standard hospice per diem for Routine Home Care
Continuous Home Care	Private home, residential care facility, board and care or nursing facility A or B level.	Standard hospice per diem for Continuous Home Care
Respite Care	Skilled nursing facility or acute facility.	Standard hospice per diem for Respite Care
General Inpatient Care	Skilled nursing or acute facility.	Standard hospice per diem for General Inpatient Care

D. For Medi-Cal primary Members, CalOptima may approve General Inpatient Care on a short-term basis for pain control or management of acute and severe problems. A Hospice Provider must submit the following documents:

1. CalOptima Hospice Notification/Validation Form (HNVF);

2. Written prescriptionPhysician orders for General Inpatient Care signed by the Member's attending Hospicehospice physician;

3. Member's Hospice Election Form;

4. Initial written planPlan of careCare;

5. Certification of Terminal Illness by a physician; and

6. Clinical documentation that indicates ~~medical necessity~~Medical Necessity for General Inpatient Care; and

7. ~~Member~~Medication Administration Records or Flow Charts that document services medically required for the General Inpatient Care.

E. Medi-Cal primary Members may be admitted for General Inpatient Care for any one (1) or more of the reasons specified below:

1. Pain control

   a. Required frequent evaluation by a physician/registered nurse;

   b. Need more aggressive treatment to control pain ~~that~~than can be attained in a home setting; or

   c. Frequent adjustment of medications.

2. Management of symptoms such as:

   a. Sudden acute general deterioration requiring intensive nursing intervention;

   b. Protracted nausea and vomiting;

   c. Respiratory distress which becomes unmanageable, requiring administration of continuous oxygen;

   d. Major pathological fracture;

   e. Open lesions not responsive to home care and in need of frequent skilled care;

   f. Rapid decline or debilitating cachexia inconsistent with home care management; and

   g. Psychological and social problems such as, but not limited to:

      i. Acute anxiety or depression not responding to milieu therapy;

      ii. Collapse of family support resulting from the disease process which requires intensive skilled care in other than the home environment; and

      iii. Psychosis or severe confusion secondary to the underlying organic disease.

F. Hospice Notification and Validation for CalOptima Medi-Cal primary Members

1. A Hospice Provider shall submit ~~notification~~Notification of Hospice election immediately and no later than thirty (30) calendar days after start of services. ~~-~~In cases of Medi-Cal retroactive eligibility, the ~~notification~~Notification must be ~~presented~~submitted within one hundred twenty (120) calendar days after the State of California's eligibility ~~is established by the Department of Health Care Services (DHCS).~~determination.

2. Notification/Validation requests submitted after ~~the~~thirty (30) calendar after start of services, or the one hundred twenty (120) calendar days requirement shall not be approved for those services rendered before the submission of a ~~complete~~completed Notification/Validation request.

3. If medical justification is not included or is inadequate for Continuous Home Care~~, Respite Care,~~ or General Inpatient Care, a CalOptima Medical Director may modify the request to a lower ~~level~~Level of ~~care~~Care pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals. ~~-~~A Hospice Provider shall have the right to appeal the ~~level~~Level of ~~care~~Care decision, in accordance with CalOptima ~~Policies~~Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services, and GG.1814: Appeal Process for Long-Term Care Facility Daily Rate Denial, Modification, or Recommendation~~.

4. The Hospice Provider shall submit ~~notification~~Notification of continued service to CalOptima or its Health Network using the Hospice Notification/Validation Form (HNVF) prior to the expiration of the current election period and shall include:

   ~~1.~~ Recertification of Terminal Illness:

      ~~i. Recertification of Terminal Illness~~ For the third benefit period re-certification, and every re-certification thereafter, there must be ~~completed by a Hospice Physician or the Hospice Medical Director from the original date of service;~~

      ~~ii. Timeframe of~~a face-to-face encounter ~~must occur~~between the Member and the certifying provider no more than thirty (30) ~~calendar~~ days prior to ~~start of the Hospice third benefit period; and~~

   ~~b.~~a. ~~Recertification may be completed no more than thirty (30) calendar days prior~~the certification date, to ~~every subsequent benefit period thereafter.~~gather clinical findings to determine continued eligibility for hospice care.

5. Attestation requirements:

   a. Face-to-face encounter with Member is required to determine eligibility and must be performed by ~~Hospice~~hospice physician or ~~Hospice~~hospice nurse practitioner employed by the Hospice Provider;

   b. Physician signature and date must be separate and a distinct section of, or an addendum to, the recertification form and must be clearly titled.

   c. Attestation performed by a nurse practitioner:

      i. Must state clinical findings of visit was provided to the certifying physician; and

      ii. Determine life expectancy of six (6) months or less, should the illness run its normal course.

6. Timeframe requirements when a Member transfers from one Hospice Provider to another Hospice Provider:

a. A receiving Hospice Provider may not know if a face-to-face recertification is necessary, as such, the receiving Hospice ~~provider~~Provider shall document in the Member's medical record all efforts to obtain the previous hospice benefit period Certification of Terminal Illness, either from the transferring Hospice ~~provider~~Provider or from other sources; and

b. If the receiving Hospice ~~provider~~Provider cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving Hospice ~~provider~~Provider completes the intake process. This information must be maintained in the Member's medical record for auditing purposes.

7. Timeframe for exceptional circumstance:

a. Face-to-face encounter is not obtained due to the Member is in the third or later benefit period; or

b. Emergency weekend admission; or

c. Centers for Medicare & Medicaid Services (CMS) Data System and/or Provider Electronic Health Record are not available; the Hospice Provider may be unaware that the Member is in the third or later benefit period. In such documented cases, a face-to-face encounter that occurs within two (2) calendar days after admission will be considered timely; or

d. Member expires within two (2) calendar days of admission without a face-to-face encounter.

8. Medically Necessary ~~services~~Covered Services for conditions not related to ~~the hospice diagnosis~~a Member's Terminal Illness that are provided to a Member receiving Hospice Care services shall require the same prior ~~authorization~~authorizations as required for a Member not receiving Hospice Care services.

9. For all CalOptima Members ~~requiring~~in an LTC facility electing Hospice Care services ~~in a LTC facility~~, the Hospice ~~provider~~Provider shall submit a completed Hospice Notification/Validation Form (HNVF) and the following documents to CalOptima's LTSS Department:

~~a. Written physician orders for hospice, including a physician signature and date;~~

a. ;

b. Initial ~~plan~~Plan of ~~care~~Care, including a physician signature and date;

c. Certification of Terminal Illness, including a physician signature and date; and

d. Hospice Election Form, including the election date and signature of the Member or the Member's Authorized Representative.

10. Pharmacy

a. Medications related to the ~~terminal condition~~Member's Terminal Illness including, but not limited to: hydration, pain, and nausea control, whether administered orally, by injection or

intravenous (IV), shall be included in the per diem hospice rate. ~~-~~These medications shall be obtained through the hospice program and not the CalOptima pharmacy system.

b. Medications required for medical conditions not related to ~~terminal care~~Member's Terminal Illness, such as insulin for a diabetic, shall continue to be covered under the CalOptima pharmacy program and shall be processed through the CalOptima pharmacy system, or by the Health Network for those drugs covered under the Health Network's responsibility.

IV. ATTACHMENT(S)

A. Notice of Election or Revocation Statement
B. Hospice Notification/Validation Form (HNVF)

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect
C. Department of Health Care Services Policy Letter (PL) 11-004: The Implementation of Section 2302 of The Affordable Care Act, Entitled "Concurrent Care For Children~~"~~
D. Department of Health Care Services All Plan Letter (APL) 13-014: Hospice Services and Medi-Cal Managed Care
E. Department of Health Care Services All Plan Letter (APL) 18-020: Palliative Care
~~E.~~F. Department of Health Care Services (DHCS) Hospice Care: General Billing Instructions
~~F.~~G. CCS Numbered Letter 04-0207: Palliative Care Options for CCS Eligible Children
H. CCS Numbered Letter 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care
~~G.~~I. Hospice Financial Responsibility Matrix
~~H.~~J. Manual of Criteria (MOC) for Medi-Cal Authorization
~~I.~~K. Title 42, Code of Federal Regulations, Section 418 et seq.
~~J.~~L. Social Security Act, Sections 1905(o)(1), 1812(d)(1) and 2110(a)(23)
~~K.~~M. Title 22, California Code of Regulations, Section 51349 and 51180 et seq.
~~L.~~N. Welfare and Institutions Code, Section 14133.85
~~M.~~O. Health and Safety Code, Sections 1368.2 and 1339.31(b)
~~N. Medi-Cal Managed Care Division (MMCD) All Plan Letter 13-014: Hospice Services and Medi-Cal Managed Care~~
~~O. CalOptima Policy GG.1325: Continuity of Care for Medi-Cal Beneficiaries Who Transition into CalOptima~~
P. CalOptima Policy GG.1508: Authorization and Processing of Referrals
Q. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
R. CalOptima Policy GG.1550: Palliative Care Services
~~R.~~S. CalOptima Policy GG.1814: Appeal Process for Long-Term Care Facility ~~Daily Rate Denial, Modification, or Recommendation~~
~~S.~~T. Medicare Claims Processing Manual, CR 9201, Chapter 11, Section 30.2.2

VI. REGULATORY AGENCY APPROVAL(s)

Date	Regulatory Agency
03/01/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2001	GG.1503	CalOptima Authorization Requirements for the Provision of Hospice Service	Medi-Cal
Revised	07/01/2007	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	10/01/2009	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	07/01/2013	GG.1503	CalOptima Coverage, Notification and Validation Requirements	Medi-Cal
Revised	03/01/2014	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal
Revised	05/01/2016	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised		GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Authorized Representative	~~Has the meaning given such term in section 164.502 (g) 45 CFR of titles 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 *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima 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~~members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Direct – Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to ~~Members~~members as described in CalOptima Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
Continuous Home Care	Hospice ~~Care~~care provided in the ~~Member's~~member's residence, which consists predominately of skilled nursing care, for a minimum of eight (8) hours in a ~~twenty-four~~ (24) -hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the ~~Member's~~member's care. (Code 0652~~)~~).

Term	Definition
Covered Services	Medi-Cal: ~~-~~Those services provided in the Fee-For-Service Medi-Cal program~~,~~ (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~ section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), ~~which~~ and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not~~-~~withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program~~.~~ OneCare Connect: ~~-~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to ~~Members~~members under the three-way agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). OneCare: ~~-~~Those medical services, equipment, or supplies that CalOptima is obligated to provide to ~~Members~~members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Crisis	The period in which a ~~Member~~member requires continuous care for as much as twenty-four (24)-hours to achieve palliation or management of acute medical symptoms.
Division of Financial Responsibility (DOFR)	A matrix that identifies 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.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
General Inpatient Care	Services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management. (Code 0656)

Term	Definition
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), or a Shared Risk 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~~covered services to ~~Members~~members assigned to that ~~Health Network~~health network.
~~Hospice Provider~~	~~A public agency or private organization, or a subdivision thereof, or a facility which:~~ ~~(1) Is primarily engaged in providing the items and services described in Title 22, California Code of Regulations, Section 51180 to terminally ill Members;~~ ~~(2)(1) Makes such services available as needed on a 24-hour basis, and~~ ~~(3) Provides bereavement counseling for the immediate family and significant others.~~
Hospice Care	The provision of palliative and supportive items and services to a ~~Terminally Ill Member~~terminally ill member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a ~~hospice provider~~Hospice Provider or by others under arrangements made by a ~~hospice provider~~Hospice Provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician ~~Services~~services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of ~~Crisis~~crisis and only as necessary to maintain the ~~Terminally Ill Member~~terminally ill member at home; 11. Inpatient ~~Respite Care~~respite care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility. 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.

Term	Definition
Hospice Intensity Service (Add-On)	For purposes of this policy, Hospice services for ~~Routine Home~~routine home hospice level of care that can be billed during the last seven (7) days of life in fifteen (15) minute increments and not to exceed four (4) hours per day for a maximum of seven (7) days. • Code G0155: Services of clinical social worker in home health or hospice setting each fifteen (15) minutes. • Code G0299: Direct skill nursing services of a registered nurse (RN) in the home health or hospice setting, each fifteen (15) minutes. • Codes do not require prior authorization with a maximum of one hundred twelve (112) units allowed for the last seven (7) days of ~~Member's~~member's life. •
Hospice Provider	A public agency or private organization, or a subdivision thereof, or a facility which: 1. Is primarily engaged in providing the items and services described in Title 22, California Code of Regulations, Section 51180 to terminally ill Members; 2. Makes such services available as needed on a 24-hour basis, and 3. Provides bereavement counseling for the immediate family and significant others.
Level of Care	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notification	For purposes of this policy, direct communication to LTSS staff for hospice services notification for routine home care, continuous and respite care -within thirty (30) calendar days of start of services for CalOptima ~~Members~~members.
Physician Services	For purposes of this policy, general supervisory services of the hospice medical director; participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician of the hospice interdisciplinary team.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).

Term	Definition
Respite Care	Hospice ~~Care~~care provided short-term inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family ~~members~~~~Members~~members or others primarily caring for the ~~Member~~member. (Code 0655)
Routine Home Care	Hospice ~~Care~~care provided in the ~~Member's~~member's residence which is not ~~Continuous Home Care.~~continuous home care. (Code 0651)
Special Physician Services	For purposes of this policy, services to manage symptoms that cannot be remedied by the ~~Member's~~member's Hospice attending physician because of one of the following: • Immediate need; and • Hospice attending physician does not have the required special skills. Code 0657 should be billed on a separate line for each date of service and is limited to once per day, per ~~Member~~member, per ~~Hospice~~hospice provider.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Terminally Ill	A medical prognosis certified by a physician is that a ~~Member's~~member's life expectancy is six (6) months or less if the ~~Terminal Illness~~terminal illness runs its normal course.
Validation	For purposes of this policy, documentation to support medical justification for services requested for CalOptima ~~Members~~members.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified 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.

Policy:	GG.1503
Title:	**CalOptima Hospice Coverage, Notification and Validation Requirements**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	
Effective Date:	06/01/2001
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

To clarify CalOptima's hospice benefit coverage, Notification and Validation requirements.

II. POLICY

A. CalOptima and its Health Networks shall be responsible for ensuring the provision of Hospice Care services for Terminally Ill Members who meet the requirements outlined in Section II.C of this policy. CalOptima and its Health Networks shall be responsible for the following, in accordance with Health Network-specific Division of Financial Responsibilities (DOFR):

1. The following Hospice Care services as determined by the Member's enrollment in a CalOptima program:

CalOptima Program	CalOptima Hospice Care Services Responsibility				
	Routine Home Hospice (Rev Code 651)	**Continuous Home Care (Rev Code 652)**	**Respite Care (Rev Code 655)**	**General Inpatient Care (Rev Code 656)**	**SNF: Room and Board (Rev Code 658)**
Medi-Cal	Yes	Yes	Yes	Yes	Yes

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CalOptima Program	CalOptima Hospice Care Services Responsibility				
	Routine Home Hospice (Rev Code 651)	**Continuous Home Care (Rev Code 652)**	**Respite Care (Rev Code 655)**	**General Inpatient Care (Rev Code 656)**	**SNF: Room and Board (Rev Code 658)**
OneCare	No*	No*	No*	No*	Yes
OneCare Connect	No*	No*	No*	No*	Yes
CalOptima Direct Administrative (COD-A) Dual eligible member	No*	No*	No*	No*	Yes
*Billed to Medicare Fee-For-Service/Original Medicare.					

2. A Member who receives services under the Whole Child Model (WCM) program who elects Hospice Care services shall continue to receive Medically Necessary treatment services for any other California Children's Services (CCS)-eligible Conditions; and

3. Room and Board coverage for a Member residing in a Long-Term Care (LTC) facility through the Medi-Cal benefit and receiving Hospice Care services.

B. Medicare Hospice Benefit Eligibility Requirements:

1. Medicare Part A (Hospital Insurance) coverage;

2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease runs its normal course);

3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and

4. The Member or Authorized Representative signs a statement choosing Hospice Care instead of other Medicare-covered treatments for the Terminal Illness and related conditions.

C. Medi-Cal Hospice Benefit Eligibility Requirements:

1. Medi-Cal is the Member's primary inpatient/hospital coverage;

2. A hospice physician (and attending physician, if any) certifies the Member's illness is terminal (life expectancy is six (6) months or less if the disease is to run its normal course);

3. The Member or Authorized Representative understands and accepts care primarily for comfort (palliative) instead of care to cure the illness (curative); and

4. The Member or Authorized Representative signs a statement choosing Hospice Care instead of other Medi-Cal covered treatments for the Terminal Illness and related conditions.

5. A Member younger than twenty-one (21) years of age, and certified by a physician as having a life expectancy of six (6) months or less, may elect to concurrently receive hospice services and palliative care in addition to curative treatment of the hospice-related diagnosis in accordance with CalOptima Policy GG.1550: Palliative Care Services.

D. A Member may elect to receive hospice benefits for two (2) election periods consisting of ninety (90) calendar days each and an unlimited number of subsequent periods of sixty (60) calendar days each. At any time during an election period, a Member may elect to revoke or modify Hospice Care. A Member or Member's Authorized Representative must file a signed statement with the Hospice Provider revoking the Member election for the remainder of the election period. A change from one designated Hospice Provider to another is not considered a revocation of the hospice election.

E. Four (4) levels of Hospice Care:

1. Routine Home Care;

2. Continuous Home Care;

3. Respite Care; and

4. General Inpatient Care.

F. Notification and Validation Requirements

1. A Member with Medicare A and B coverage living in the community (not in an LTC facility) shall be exempt from all Notification requirements related to coverage of professional services for hospice.

2. For OneCare Connect, OneCare, and Medi-Cal primary Members, the Hospice Provider shall notify and coordinate with CalOptima or the Member's assigned Health Network for covered healthcare services that are unrelated to the Terminal Illness.

3. Medi-Cal primary Members may access Hospice Care within twenty-four (24) hours of Notification of Hospice request. CalOptima shall not require prior authorization for Hospice Care services under Routine Home Care, Continuous Home Care, and Respite Care levels of Hospice Care. A Hospice Provider shall provide documentation to support these levels of care.

Level of Care	Notification	Validation
Routine Home Care	Notification Required – within thirty (30) calendar days of start of service.	Required for each certification period – two (2) ninety (90) calendar day periods, then unlimited 60 calendar day periods. Certification of Terminal Illness documentation must be presented prior to the expiration of the current certification period.
Continuous Home Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate the Member has received a minimum of eight (8) hours of direct care within a twenty-four (24)-hour period.
Respite Care	Notification Required – within thirty (30) calendar days of start of service.	Submit documentation to validate that Member received Respite Care. Retroactive approval will be granted on an intermittent, non-routine basis, up to five (5) consecutive days at a time.
General Inpatient Care	Authorization Required. Notification required within one (1) business day but no more than seven (7) calendar days of start of service.	Required – authorization will be granted in seven (7) day intervals upon Validation of medical needs justification
Service Intensity Add-on	Notification required within twenty-four (24) hours after Member's death	Submit documentation to validate the Member has received service provided by a Social Worker or Registered Nurse during the last seven (7) days of life for a minimum of fifteen (15) minutes and a maximum of four (4) hours per day up to seven (7) days
Special Physician Services	Notification required within thirty (30) calendar days of start of service	Submit documentation to validate the Member has received services provided by a physician specializing in services that meets the Member's specific needs, and the hospice employed physician is unable to meet the Member's needs, and limited to one (1) visit per day per Member

4. For Medi-Cal primary Members requiring General Inpatient Care, planned or unplanned admissions, a Hospice Provider shall submit an authorization request for hospice services within the next business day or no later than seven (7) calendar days after the start of services. If a hospice provider does not provide adequate clinical documentation or documents do not substantiate the need for General Inpatient Care, the CalOptima Medical Director may reduce the Level of Care to Routine Home Care. Following such a decision, the Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Policies GG.1510: Appeal Process and GG.1814: Appeal Process for Long-Term Care Facility.

5. Notification for Routine Home Care during the last seven (7) days of life – Service Intensity Add-On (SIA)

   a. If a Medi-Cal primary Member was determined to be in the last seven (7) days of life, the Hospice Provider shall notify CalOptima within twenty-four (24) hours of Member's expiration and request SIA when the following criteria are met:

      i. The day was a Routine Home Care Level of Care day;

ii. The days occurred during the last seven (7) days of life and the Member expired;

iii. The service was provided in-person by a Social Worker or a Registered Nurse; and

iv. The SIA number of hours (in fifteen (15) minute increments) of service provided by a Registered Nurse or Social Worker during the last seven (7) days of life met a minimum of fifteen (15) minutes and a maximum of four (4) hours per day, up to seven (7) days, not to exceed a combined maximum of 112 units.

6. If a CalOptima Member, regardless of CalOptima program enrollment, utilizes Hospice Care services in a LTC facility, the Hospice Provider shall submit Notification for facility services (room and board) to the CalOptima Long Term Services and Supports (LTSS) Department.

   a. The Hospice Provider shall submit a Notification for hospice services for a CalOptima Medi-Cal Member within thirty (30) calendar days after the start of services for the following Hospice Level of Care services utilizing the Hospice Validation / Notification Form (HVNF) to include the dates of service along with documentation of services provided:

      i. Continuous Home Care;

      ii. Routine Home Care;

      iii. Respite Care; and

      iv. Special physician services.

G. Member requests to change a Hospice Provider, the current Hospice Provider shall provide a transferring Member with a transfer summary signed by the Member's hospice physician. The transfer summary shall include, but not be limited to the following information:

1. Member's diagnosis;

2. Pain treatment, and management;

3. Medications;

4. Medical treatments;

5. Dietary requirement;

6. Known allergies;

7. Treatment plan; and

8. Previous hospice benefit period information.

H. A Member who moves his or her legal residence outside of Orange County must disenroll from CalOptima. Hospice Providers shall provide transferring Members with a transfer summary which shall be signed by the physician. Upon enrollment in the new county, a "change in designated hospice" must be initiated. This may be done only once per election period.

I. CalOptima and its Health Networks, in accordance with the active DOFR, shall pay the standard per diem set by Medi-Cal to all Hospice Providers for Medi-Cal primary Members. For a Member who has Medicare and Medi-Cal residing in an LTC facility, the Hospice Provider shall bill Medicare for the hospice services and bill CalOptima for room and board.

J. CalOptima and its Health Networks, in accordance with the active DOFR, shall pay two (2) different Routine Home Care rates for Medi-Cal primary Members, based upon the following:

1. Routine Home Care high rate: defined as day one (1) to sixty (60) of an episode; and

2. Routine Home Care low rate: defined as day sixty-one (61) and beyond.

3. For a Member who is discharged and readmitted to hospice within sixty (60) calendar days of that discharge, the Member's hospice days will continue to follow the patient and count toward the Member days for the receiving hospice in the determination of whether the receiving Hospice Provider may be considered at the high or low Routine Home Care rate, upon hospice election.

4. For a Member who has been discharged from Hospice Care for more than sixty (60) calendar days, a new election to Hospice will initiate a reset of the Member's sixty (60) calendar day window and it is considered at the Routine Home Care high rate upon the new Hospice election.

K. Special Physician Services for Medi-Cal primary Members

1. A Hospice Provider shall submit a Notification with medical justification including diagnoses related to the Member's Terminal Illness. CalOptima shall review and make medical determination for requests for Special Physician Services for pain and symptom management based on medical justification. The Special Physician Services shall not be provided by the Member's Hospice attending physician and requires:

a. Immediate need; and

b. The Hospice attending physician does not have the required special skills.

2. Special Physician Services is limited to one (1) visit-per-day, per Member.

L. CalOptima and its Health Networks, in accordance with the Health Network-specific DOFR, are responsible for the provision of all Medically Necessary Covered Services not related to a Member's Terminal Illness , including covered services provided by a Member's Primary Care Provider (PCP).

M. CalOptima or its Health Network, in accordance with the active DOFR, may provide ongoing care coordination to a OneCare Connect, OneCare, or Medi-Cal primary Member receiving Hospice Care to ensure that services necessary to diagnose, treat, and follow-up on conditions not related to the Terminal Illness continue to be provided, or are initiated, as necessary.

N. The Member may still receive medical services not related to the Terminal Illness through Medicare Part A and B or a Medicare health plan.

O. CalOptima shall not approve any claims requests submitted after one (1) year from the date of service.

P. For exceptional circumstances, Hospice Providers that submit a claim after twelve (12) months from the month of service shall provide acceptable documentation justifying the reason for delay. Acceptable documentation may include:

1. Court decisions;

2. Fair hearing decisions;

3. County administrative errors in determining Member eligibility;

4. Reversal of decisions on appealed Authorization Request Form (ARF);

5. Medicare/Other Health coverage delays; or

6. Other circumstances beyond the Hospice Provider's control (i.e., natural disasters).

Q. CalOptima shall ensure for any authorizations for which it is responsible, for Hospice Care services under the Medi-Cal benefit, are consistently applied to medical/surgical, mental health, and substance use disorder services.

III. PROCEDURE

A. CalOptima or its Health Networks, in accordance with the Health Network-specific DOFR, shall be responsible for providing Hospice Care to a Medi-Cal primary Member if the following criteria are validated:

1. The physician has executed a certification of Terminal Illness that complies with 42 CFR §418.22.

2. The Notice of Election or Revocation Statement is signed by the Member or Member's Authorized Representative. The following must be included on the form:

a. Identification of the Hospice Provider;

b. The Member's or the Member's Authorized Representative's acknowledgement that he or she has full understanding that the Hospice Care services given as related to the Member's Terminal Illness will be palliative, rather than curative in nature, unless the Member is a child under twenty-one (21) years of age, and that certain specified Medi-Cal benefits are waived by the election;

c. The effective date of election; and

d. The signature of the Member or the Member's Authorized Representative.

B. A Hospice Provider shall be responsible for services related to the Member's Terminal Illness, including, but not limited to, pharmacy, physician, social services, nursing, home health aide services, home maker services, Durable Medical Equipment (DME), supplies, multi-disciplinary hospice services, hospice physician consultation for patients, dietary or nutritional counseling, bereavement, and grief and spiritual counseling.

C. For a Member residing in an LTC facility, reimbursement will follow the Level of Care table below:

Level of Care	Service Location	Payment
Routine Home Care	Private home, residential care facility, board and care or nursing facility A or B level.	Standard hospice per diem for Routine Home Care
Continuous Home Care	Private home, residential care facility, board and care or nursing facility A or B level.	Standard hospice per diem for Continuous Home Care
Respite Care	Skilled nursing facility or acute facility.	Standard hospice per diem for Respite Care
General Inpatient Care	Skilled nursing or acute facility.	Standard hospice per diem for General Inpatient Care

D. For Medi-Cal primary Members, CalOptima may approve General Inpatient Care on a short-term basis for pain control or management of acute and severe problems. A Hospice Provider must submit the following documents:

1. CalOptima Hospice Notification/Validation Form (HNVF);
2. Physician orders for General Inpatient Care signed by the Member's attending hospice physician;
3. Member's Hospice Election Form;
4. Initial written Plan of Care;
5. Certification of Terminal Illness by a physician;
6. Clinical documentation that indicates Medical Necessity for General Inpatient Care; and
7. Medication Administration Records or Flow Charts that document services medically required for the General Inpatient Care.

E. Medi-Cal primary Members may be admitted for General Inpatient Care for any one (1) or more of the reasons specified below:

1. Pain control
   a. Required frequent evaluation by a physician/registered nurse;
   b. Need more aggressive treatment to control pain than can be attained in a home setting; or
   c. Frequent adjustment of medications.
2. Management of symptoms such as:
   a. Sudden acute general deterioration requiring intensive nursing intervention;
   b. Protracted nausea and vomiting;

c. Respiratory distress which becomes unmanageable, requiring administration of continuous oxygen;

d. Major pathological fracture;

e. Open lesions not responsive to home care and in need of frequent skilled care;

f. Rapid decline or debilitating cachexia inconsistent with home care management; and

g. Psychological and social problems such as, but not limited to:

i. Acute anxiety or depression not responding to milieu therapy;

ii. Collapse of family support resulting from the disease process which requires intensive skilled care in other than the home environment; and

iii. Psychosis or severe confusion secondary to the underlying organic disease.

F. Hospice Notification and Validation for CalOptima Medi-Cal primary Members

1. A Hospice Provider shall submit Notification of Hospice election immediately and no later than thirty (30) calendar days after start of services. In cases of Medi-Cal retroactive eligibility, the Notification must be submitted within one hundred twenty (120) calendar days after the State of California's eligibility determination.

2. Notification/Validation requests submitted after thirty (30) calendar after start of services, or the one hundred twenty (120) calendar days requirement shall not be approved for those services rendered before the submission of a completed Notification/Validation request.

3. If medical justification is not included or is inadequate for Continuous Home Care or General Inpatient Care, a CalOptima Medical Director may modify the request to a lower Level of Care pursuant to CalOptima Policy GG.1508: Authorization and Processing of Referrals. A Hospice Provider shall have the right to appeal the Level of Care decision, in accordance with CalOptima Policy GG.1510: Appeal Process.

4. The Hospice Provider shall submit Notification of continued service to CalOptima or its Health Network using the Hospice Notification/Validation Form (HNVF) prior to the expiration of the current election period and shall include:

a. Recertification of Terminal Illness: For the third benefit period re-certification, and every re-certification thereafter, there must be a face-to-face encounter between the Member and the certifying provider no more than thirty (30) days prior to the certification date, to gather clinical findings to determine continued eligibility for hospice care.

5. Attestation requirements:

a. Face-to-face encounter with Member is required to determine eligibility and must be performed by hospice physician or hospice nurse practitioner employed by the Hospice Provider;

b. Physician signature and date must be separate and a distinct section of, or an addendum to, the recertification form and must be clearly titled.

c. Attestation performed by a nurse practitioner:

i. Must state clinical findings of visit was provided to the certifying physician; and

ii. Determine life expectancy of six (6) months or less, should the illness run its normal course.

6. Timeframe requirements when a Member transfers from one Hospice Provider to another Hospice Provider:

a. A receiving Hospice Provider may not know if a face-to-face recertification is necessary, as such, the receiving Hospice Provider shall document in the Member's medical record all efforts to obtain the previous hospice benefit period Certification of Terminal Illness, either from the transferring Hospice Provider or from other sources; and

b. If the receiving Hospice Provider cannot determine the correct benefit period, the face-to-face recertification clock starts from the time the receiving Hospice Provider completes the intake process. This information must be maintained in the Member's medical record for auditing purposes.

7. Timeframe for exceptional circumstance:

a. Face-to-face encounter is not obtained due to the Member is in the third or later benefit period; or

b. Emergency weekend admission; or

c. Centers for Medicare & Medicaid Services (CMS) Data System and/or Provider Electronic Health Record are not available; the Hospice Provider may be unaware that the Member is in the third or later benefit period. In such documented cases, a face-to-face encounter that occurs within two (2) calendar days after admission will be considered timely; or

d. Member expires within two (2) calendar days of admission without a face-to-face encounter.

8. Medically Necessary Covered Services for conditions not related to a Member's Terminal Illness that are provided to a Member receiving Hospice Care services shall require the same prior authorizations as required for a Member not receiving Hospice Care services.

9. For all CalOptima Members in an LTC facility electing Hospice Care services, the Hospice Provider shall submit a completed Hospice Notification/Validation Form (HNVF) and the following documents to CalOptima's LTSS Department:

a. ;

b. Initial Plan of Care, including a physician signature and date;

c. Certification of Terminal Illness, including a physician signature and date; and

d. Hospice Election Form, including the election date and signature of the Member or the Member's Authorized Representative.

10. Pharmacy

    a. Medications related to the Member's Terminal Illness including, but not limited to: hydration, pain, and nausea control, whether administered orally, by injection or intravenous (IV), shall be included in the per diem hospice rate. These medications shall be obtained through the hospice program and not the CalOptima pharmacy system.

    b. Medications required for medical conditions not related to Member's Terminal Illness, such as insulin for a diabetic, shall continue to be covered under the CalOptima pharmacy program and shall be processed through the CalOptima pharmacy system, or by the Health Network for those drugs covered under the Health Network's responsibility.

IV. ATTACHMENT(S)

A. Notice of Election or Revocation Statement
B. Hospice Notification/Validation Form (HNVF)

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services for Medi-Cal
B. Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for Cal MediConnect
C. Department of Health Care Services Policy Letter (PL) 11-004: The Implementation of Section 2302 of The Affordable Care Act, Entitled "Concurrent Care For Children
D. Department of Health Care Services All Plan Letter (APL) 13-014: Hospice Services and Medi-Cal Managed Care
E. Department of Health Care Services All Plan Letter (APL) 18-020: Palliative Care
F. Department of Health Care Services (DHCS) Hospice Care: General Billing Instructions
G. CCS Numbered Letter 04-0207: Palliative Care Options for CCS Eligible Children
H. CCS Numbered Letter 06-1011: Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care
I. Hospice Financial Responsibility Matrix
J. Manual of Criteria (MOC) for Medi-Cal Authorization
K. Title 42, Code of Federal Regulations, Section 418 et seq.
L. Social Security Act, Sections 1905(o)(1), 1812(d)(1) and 2110(a)(23)
M. Title 22, California Code of Regulations, Section 51349 and 51180 et seq.
N. Welfare and Institutions Code, Section 14133.85
O. Health and Safety Code, Sections 1368.2 and 1339.31(b)
P. CalOptima Policy GG.1508: Authorization and Processing of Referrals
Q. CalOptima Policy GG.1510: Appeal Process
R. CalOptima Policy GG.1550: Palliative Care Services
S. CalOptima Policy GG.1814: Appeal Process for Long-Term Care Facility
T. Medicare Claims Processing Manual, CR 9201, Chapter 11, Section 30.2.2

VI. REGULATORY AGENCY APPROVAL(s)

Date	Regulatory Agency
03/01/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/01/2001	GG.1503	CalOptima Authorization Requirements for the Provision of Hospice Service	Medi-Cal
Revised	07/01/2007	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	10/01/2009	GG.1503	CalOptima Hospice Coverage and Authorization Requirements	Medi-Cal
Revised	07/01/2013	GG.1503	CalOptima Coverage, Notification and Validation Requirements	Medi-Cal
Revised	03/01/2014	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal
Revised	05/01/2016	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare Connect
Revised	01/01/2018	GG.1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect
Revised		GG. 1503	CalOptima Hospice Coverage, Notification and Validation Requirements	Medi-Cal OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
California Children's Services (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible individuals under the age of twenty-one (21) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR) Sections 41515.2 through 41518.9.
California Children's Services-eligible Conditions	Chronic medical conditions, including but not limited to, cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries and infectious disease producing major sequelae as defined in Title 22, California Code of Regulations sections 41515.2 through 41518.9.
CalOptima 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 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.
Continuous Home Care	Hospice care provided in the member's residence, which consists predominately of skilled nursing care, for a minimum of eight (8) hours in a 24-hour period, for the palliation or management of acute medical symptoms and/or when the family or caregiver is physically or emotionally unable to manage the member's care. (Code 0652).

Term	Definition
Covered Services	Medi-Cal: Those services provided in the Fee-For-Service Medi-Cal program (as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to members under the three-way agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS). OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to members under the Centers of Medicare & Medicaid Services (CMS) Contract.
Crisis	The period in which a member requires continuous care for as much as twenty-four (24)-hours to achieve palliation or management of acute medical symptoms.
Division of Financial Responsibility (DOFR)	A matrix that identifies 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.
Durable Medical Equipment (DME)	Durable medical equipment means equipment prescribed by a licensed practitioner to meet medical equipment needs of the Member that: 1. Can withstand repeated use. 2. Is used to serve a medical purpose. 3. Is not useful to an individual in the absence of an illness, injury, functional impairment, or congenital anomaly. 4. Is appropriate for use in or out of the patient's home.
General Inpatient Care	Services in an acute hospital, skilled nursing facility/Level B, or a hospice facility which is organized to provide inpatient care directly, for the purpose of pain control or acute or chronic symptom management. (Code 0656)
Health Network	For purposes of this policy, a Physician-Hospital Consortia (PHC), or a Shared Risk 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
Hospice Care	The provision of palliative and supportive items and services to a terminally ill member as defined in Title 22 CCR section 51180.2, who has voluntarily elected to receive such care in lieu of curative treatment related to the terminal condition, by a Hospice Provider or by others under arrangements made by a Hospice Provider, including: 1. Nursing services; 2. Physical or occupational therapy, or speech-language pathology; 3. Medical social services under the direction of a physician; 4. Home health aide and homemaker services; 5. Medical supplies and appliances; 6. Drugs and biologicals; 7. Physician services; 8. Short-term inpatient care for pain control or symptom management in a hospital, skilled nursing or hospice facility; 9. Counseling, including bereavement, dietary and spiritual counseling; 10. Continuous nursing services provided on a twenty-four (24)-hour basis only during periods of crisis and only as necessary to maintain the terminally ill member at home; 11. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five (5) consecutive days at a time in a hospital, skilled nursing or hospice facility. 12. Any other palliative item or service for which payment may otherwise be made under the Medi-Cal program and that is included in the Hospice plan of care.
Hospice Intensity Service (Add-On)	For purposes of this policy, Hospice services for routine home hospice level of care that can be billed during the last seven (7) days of life in fifteen (15) minute increments and not to exceed four (4) hours per day for a maximum of seven (7) days. • Code G0155: Services of clinical social worker in home health or hospice setting each fifteen (15) minutes. • Code G0299: Direct skill nursing services of a registered nurse (RN) in the home health or hospice setting, each fifteen (15) minutes. • Codes do not require prior authorization with a maximum of one hundred twelve (112) units allowed for the last seven (7) days of member's life.
Hospice Provider	A public agency or private organization, or a subdivision thereof, or a facility which: 1. Is primarily engaged in providing the items and services described in Title 22, California Code of Regulations, Section 51180 to terminally ill Members; 2. Makes such services available as needed on a 24-hour basis, and 3. Provides bereavement counseling for the immediate family and significant others.
Level of Care	Criteria for determining admission to a LTC facility contained in Title 22, CCR, Sections 51334 and 51335 and applicable CalOptima policies.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Notification	For purposes of this policy, direct communication to LTSS staff for hospice services notification for routine home care, continuous and respite care within thirty (30) calendar days of start of services for CalOptima members.
Physician Services	For purposes of this policy, general supervisory services of the hospice medical director; participation in the establishment of plans of care, supervision of care and services, periodic review and updating of plans of care, and establishment of governing policies by the physician of the hospice interdisciplinary team.
Plan of Care	An individual written plan of care completed, approved, and signed by a physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Respite Care	Hospice care provided short-term inpatient care in an acute hospital, skilled nursing facility/Level B, intermediate care facility/Level A, or a hospice facility which is organized to provide inpatient care directly, when necessary to relieve family members or others primarily caring for the member. (Code 0655)
Routine Home Care	Hospice care provided in the member's residence which is not continuous home care. (Code 0651)
Special Physician Services	For purposes of this policy, services to manage symptoms that cannot be remedied by the member's Hospice attending physician because of one of the following: • Immediate need; and • Hospice attending physician does not have the required special skills. Code 0657 should be billed on a separate line for each date of service and is limited to once per day, per member, per hospice provider.
Terminal Illness	An incurable or irreversible condition that has a high probability of causing death within one (1) year or less.
Terminally Ill	A medical prognosis certified by a physician is that a member's life expectancy is six (6) months or less if the terminal illness runs its normal course.
Validation	For purposes of this policy, documentation to support medical justification for services requested for CalOptima members.
Whole-Child Model (WCM)	An organized delivery system established for Medi-Cal eligible CCS children and youth, pursuant to California Welfare & Institutions Code (commencing with Section 14094.4), and that (i) incorporates CCS covered services into Medi-Cal managed care for CCS-eligible Members and (ii) integrates Medi-Cal managed care with specified 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.

1

Hospice Agency Name:_____

Medi-Cal ID#_____

Address: _____

_____

Phone Number: (_____)_____-_____

Notification of Hospice Election/Revocation

Member Name:

Date of Birth:

Social Security Number:

Name of Residence:

Services elected:

Hospice Provider:

Effective Date of Hospice Election:
(Attach Copy of Signed Election Form)

Effective date of Hospice Revocation:

From:

Phone No: ( ) _____

Mail to:
Attn: Hospice Clerk,
DHCS, Medi-Cal Eligibility Branch,
MS 4607, 1501 Capitol Avenue, Room 4063,
P.O. Box 997417-7417
Sacramento, CA 95899-7417

CalOptima
Public Agency
Better. Together.

P.O. BOX 11045
ORANGE, CA 92856
Phone 714-246-8444
Fax 714-246-8843

For CalOptima Use Only REFERENCE NO:	*For CalOptima Use Only* Status: ☐ Request Validated ☐ Denied ☐ Modified ☐ Deferred From: To:

Hospice Notification/Validation Form (HNVF)

☐ Initial Validation (90 days) ☐ Re-certification ☐ Retroactive

SECTION I

PROVIDER: Notification/Validation does not guarantee payment.
CalOptima ELIGIBILITY must be verified at the time services are rendered.

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

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

Social Security #: **Client Index #:** **Aid Code:** **County Code:**

Hospice Provider:	**Physician Name:**
Address:	**Address:**
Phone:	**Phone:**
Fax:	**Physician Medi-Cal ID #:**
Medi-Cal Provider ID #:	**Diagnosis Code:**
Office Contact:	

Hospice Start Date: **Dates of Service:** **From:** **To:**

SECTION II

Hospice Billing Codes: **# of Units (Days)**

- ☐ 0651 Routine Home Care
- ☐ 0652 Continuous Home Care
- ☐ 0655 Respite Care
- ☐ 0656/T2045 General Inpatient Care _____
- ☐ 0657 Special Physician Services _____
- ☐ 0658 Hospice Room and Board _____
- ☐ G0155 Clerical Social Worker Services _____
- ☐ G0299 Registered Nurse Services _____
- ☐ Other

SECTION III

Place of Service

SNF ☐ Yes or ☐ No

If Yes, Name of Facility: _____

Home ☐ Yes or ☐ No

SECTION IV

Documentation Attached:

- ☐ Written order signed by attending physician
- ☐ Patient's Hospice Election Form
- ☐ Initial Written Plan of Care
- ☐ Certification of Terminal Illness by M.D.
- ☐ DHS 6194
- ☐ Face-to-Face Encounter

SECTION V

- ☐ Election Date: _____
- ☐ Revocation Date: _____
- ☐ Expiration Date: _____
- ☐ Other: _____

DO NOT WRITE BELOW THIS LINE **FOR CalOptima USE ONLY**

COMMENTS:

Signature: **Date:** **Phone Number:**

Revised 06/2016

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Policy:	GG.1808
Title:	**Plan of Care, Long-Term Care**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy delineates requirements for an individually written Plan of Care for Members admitted to a Long-Term Care (LTC) facility, including a Skilled Nursing Facility for Nursing Facility (NF-A), Nursing Facility (NF-B) Level of Care, and Subacute Facility-Adult/Pediatric, and to ensure CalOptima Members receive coordinated care across continuum of services including medical, behavioral health, and long-term services and supports.

II. POLICY

A. CalOptima Members admitted to ~~a Nursing Facility~~an LTC facility shall have an individually written Plan of Care completed, approved, and signed by a physician.

B. ~~A Nursing Facility~~An LTC facility shall maintain a Member's Plan of Care in the Member's Medical Record at the ~~Nursing Facility~~LTC facility.

~~C. A Nursing Facility may modify a CalOptima Member's care, or discharge, with appropriate physician signature approval, if the following specified circumstances are present:~~

~~1. The Nursing Facility is no longer capable of meeting the Member's health care needs;~~

~~2. The Member's health care has improved sufficiently, so that the Member no longer needs Nursing Facility services; or~~

~~3. The Member poses a risk to the health or safety of individuals in the facility.~~

~~D.~~C. CalOptima or a Health Network shall participate in Member's Interdisciplinary Care Team (ICT) meeting, as appropriate. ~~When one (1) of the circumstances above presents itself, the Nursing Facility shall arrange, coordinate, and collaborate with CalOptima to discharge a CalOptima Member to the appropriate setting, and may include referrals to Home and Community Based Services (HCBS).~~

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~~E. Discharge Planning:~~

~~1. CalOptima or a Health Network shall be responsible for ensuring the provision of a Member's medical needs, supports, and services throughout the post-discharge and transition to community-based care period. The discharge planning may include, but is not limited to:~~

~~a. Documentation of pre-admission, or baseline status;~~

~~b. Initial set up of services needed after discharge, including but not limited to medical care, medication, durable medical equipment, identification and integration of community based LTSS programs;~~

~~c. Initial coordination of care, as appropriate with the Member's caregiver, other agencies and knowledgeable personnel, as well as ensuring the Member's care coordinator contact information for hospitals; and~~

~~d. Provision of information for making follow-up appointments.~~

~~2. CalOptima or a Health Network shall be responsible for ensuring that all Medically Necessary services are provided in a timely manner upon discharge, and that a Member's transition to the most appropriate level of care and community-based care occurs, from the Skilled Nursing Facility, that meets the Member's medical and social needs.~~

III. PROCEDURE

A. ~~A Nursing Facility~~An LTC facility shall incorporate the Member's transferring Medical Records, previous facility discharge plan, and Health Risk Assessment (HRA), if applicable, in the Member's current Plan of Care.

B. A CalOptima or Health Network case manager shall contact ~~Nursing Facility~~the LTC facility staff when appropriate to:

1. Request a Member's ICT meeting schedule;

2. Inform the ~~Nursing Facility~~LTC facility staff that the case manager would like to participate and obtain permission to attend Member's ICT;

3. Provide a copy of Member's completed HRA to the facility staff;

4. Provide additional resources and care coordination as appropriate; and

5. Document ICT participation and findings in the Member's Medical Record.

C. ~~A Nursing Facility~~An LTC facility ICT case conference may include physician(s), nurse(s), therapist(s), ~~a~~ social worker~~,~~(s), and other health care professionals. The ~~members~~Members of the ICT shall contribute to and~~/or~~ establish ~~a~~the written Plan of Care for a Member ~~before requesting authorization from CalOptima~~. The Plan of Care shall include, but is not limited to the following:

1. Diagnoses, symptoms, complaints, and complications ~~indicating a need for facility admission~~;

2. ~~A description~~Description of the functional and cognitive level of the Member;

3. Psychosocial status;

4. Caregiver involvement and support system;

5. Objectives for the Member during the facility stay;

6. Any orders for:

   a. Medications;

   b. Treatments;

   c. Restorative and rehabilitative services;

   d. Activities;

   e. Therapies;

   f. Social services;

   g. Diet;

   h. Special procedures recommended for the health and safety of the Member; and

   i. Special procedures designed to meet the ~~objective~~objectives of the Plan of Care;

7. Plans for continuing care, including review and modification of the Plan of Care;

8. Plans for discharge; and

9. Plans for leaves of absence ~~and summer camp~~, if applicable.

D. The attending physician, or Primary Care Provider (PCP), and other health care professional involved in the Member's care, shall review, discuss care goals with the Member and/or the ~~Member's~~Member's Authorized Representative, and sign each Plan of Care ~~per contractual agreement.~~ In addition, the attending physician~~,~~ or PCP, and other personnel involved in the Member's care, must review, update as appropriate, and sign each Plan of Care at least every sixty (60) calendar days. ~~for level NF-B, and ninety (90) calendar days for level NF-A, Subacute Adult, and Subacute Pediatric.~~

E. The Member or the Member's Authorized Representative must be offered ~~and provided a copy of the CalOptima ICP, if applicable, and~~ their Plan of Care, as well as any amendments to it if applicable, by the ~~ICP. The ICP must be made available in alternative formats and in the Member's preferred written or spoken language upon request.~~LTC Facility staff. If assistance with translation is required, the LTC Facility or CalOptima can provide translation services as needed.

F. CalOptima LTSS, or Health Network staff, may review the Member's Plan of Care as ~~applicable on an annual basis, or as~~ a Member's health condition changes or to provide additional care coordination, including but not limited to Member events such as:

1. ~~A visit~~Visit(s) to the emergency room;

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2. Admission(s) to an acute hospital;

3. ~~A sudden increase~~Significant increases in Polypharmacy; and

4. ~~Initial and annual~~Findings from Health Risk ~~Assessment~~Assessments.

~~G. A Nursing Facility shall include referrals to the following community-based services in a Member's discharge plan of care, as appropriate:~~

~~1. Community Based Adult Services (CBAS);~~

~~2. In-Home Supportive Services (IHSS);~~

~~3. Multipurpose Senior Services Program (MSSP);~~

~~4. Program of All-Inclusive Care for the Elderly (PACE);~~

~~5. Section 8 House Authority;~~

~~6. Other Home and Community Based Services; and~~

~~7. Other Waiver Programs.~~

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy CMC.6031: Health Risk Assessment
C. CalOptima Policy GG.1323: Seniors and Persons with Disabilities (SPD) Health Risk Assessment
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~E.~~ Department of Health Care Services (DHCS) ~~All Plan Letter (APL) 15-004: Medi-Cal Managed Care Health Plan Requirements for Nursing Facility Services in Coordinated Care Initiative Counties for Beneficiaries Not Enrolled in Cal MediConnect".~~
~~F.~~E. ~~Department of Health Care Services(DHCS)~~ Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
~~G.~~F. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 16-003: Discharge Planning for Cal MediConnect
~~H.~~G. Medi-Cal Provider Manual: Patients Plans of Care for Long-Term Care
~~I.~~H. Title 22, California Code of Regulations (CCR), §§ 51118, 51120, 51121, 51124, 51164-51164.2, 51212, 51215, 51215.5, 51215.8, 51343(g), 51343.1(f), 51343.2(h), ~~51343.1(f)~~, ~~51343(g)~~, 76079, 76345 and 76853
~~J.~~I. Title 42, Code of Federal Regulations (CFR), §§ 456.80 and 456.380

~~IV.~~VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services (DHCS)

~~V.~~VII. BOARD ~~ACTIONS~~ACTION(S)

None to Date

~~VI.~~VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1808	Plan of Care, Long-Term Care	Medi-Cal
Revised	07/01/2007	GG.1808	Plan of Care, Long-Term Care	Medi-Cal
Effective	07/01/2015	CMC.1808	Plan of Care, Long-Term Care	OneCare Connect
Revised	02/01/2016	GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect
Retired	03/08/2016	CMC.1808	Plan of Care, Long Term Care	OneCare Connect
Revised	10/01/2016	GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect
Revised		GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect

~~VII.~~IX. GLOSSARY

Term	Definition
Authorized Representative	Medi-Cal: ~~Has the meaning given such term 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 *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors. OneCare Connect: Services must be provided in a way that provides all protections to the Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means 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 under WIC Section 14059.5.
Community-Based Adult Services (CBAS)	An outpatient, facility based -program that delivers skilled nursing care, social services, therapies, personal care, family/caregiver training and support, nutrition services, transportation, and other services, as defined in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91, to eligible Members who meet applicable eligibility criteria~~to eligible Members who meet applicable eligibility criteria.~~.
Health Network	For purposes of this policy, 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 Risk Assessment (HRA)	A health questionnaire, used to provide Members with an evaluation of their health risks and quality of life.
Home and Community-Based Services (HCBS)	Home and Community- Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
In-Home Supportive Services (IHSS)	Services provided for Members in accordance with the requirements set forth in Welfare and Institutions Code Section 14186.1(c) (1).
Interdisciplinary Care Team (ICT)	A team comprised of the primary care provider and care coordinator, and other providers at the discretion of the Member, that works with the Member to develop, implement, and maintain the ICP.
Long-Term Care (LTC)	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.

Term	Definition
Medical Record	Medi-Cal: Any single, complete record kept or required to be kept by any Provider that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy. OneCare Connect: A medical record, health record, or medical chart in general is a systematic documentation of a single individual's medical history and care over time. The term 'Medical Record' is used both for the physical folder for each individual patient and for the body of information which comprises the total of each patient's health history. Medical records are intensely personal documents and there are many ethical and legal issues surrounding them such as the degree of third-party access and appropriate storage and disposal.
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary ~~services~~ Covered 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~~.~~, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v). OneCare Connect: ~~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. Services~~ Services must be provided in a way that provides all protections to the ~~Enrollee~~Member provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary Covered Services for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, medical necessity means 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 under WIC Section 14059.5.
Member	A beneficiary enrolled in a CalOptima program.
Multi-Purpose Senior Services Program (MSSP)	The Waiver program that provides social and health care management to a Member who is sixty-five (65) years or older and meets a nursing facility level of care as an alternative to nursing facility placement in order to allow the Member to remain in their home.
Nursing Facility	Refers to Nursing Facility Level A and Nursing Facility Level B facilities.
Nursing Facility Level A (NF-A)	Level of care characterized by scheduled and predictable nursing needs with a need for protective and supportive care, but without the need for continuous, licensed nursing.

Term	Definition
Nursing Facility Level B (NF-B)	Level of care is characterized by an individual requiring the continuous availability of skilled nursing care provided by a licensed registered or vocational nurse yet does not require the full range of health care services provided in a hospital as hospital acute care or hospital extended care.
Plan of Care	An individual written plan of care completed, approved, and signed by a Physician and maintained in the member's medical records according to Title 42, Code of Federal Regulations (CFR).
Polypharmacy	For the purposes of this policy, the simultaneous use of multiple medications by a single Member, for one (1) or more conditions which may increase the risk for drug interactions and adverse drug reactions.
Primary Care Provider (PCP)	A ~~Primary Care Provider may be a Primary Care Practitioner, or other institution or facility~~person responsible for supervising, coordinating, and providing initial and ~~primary care~~Primary Care to ~~Members~~patients; for initiating referrals; and ~~serves as~~for maintaining the ~~medical home for Members~~continuity of patient care. A PCP may be a Primary Care Physician or Non-Physician Medical Practitioner.
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.
Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

Policy:	GG.1808
Title:	**Plan of Care, Long-Term Care**
Department:	Medical Management
Section:	Long Term Services and Supports
CEO Approval:	
Effective Date:	01/01/1996
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy delineates requirements for an individually written Plan of Care for Members admitted to a Long-Term Care (LTC) facility, including a Skilled Nursing Facility for Nursing Facility (NF-A), Nursing Facility (NF-B) Level of Care, and Subacute Facility-Adult/Pediatric and to ensure CalOptima Members receive coordinated care across continuum of services including medical, behavioral health, and long-term services and supports.

II. POLICY

A. CalOptima Members admitted to an LTC facility shall have an individually written Plan of Care completed, approved, and signed by a physician.

B. An LTC facility shall maintain a Member's Plan of Care in the Member's Medical Record at the LTC facility.

C. CalOptima or a Health Network shall participate in Member's Interdisciplinary Care Team (ICT) meeting, as appropriate.

III. PROCEDURE

A. An LTC facility shall incorporate the Member's transferring Medical Records, previous facility discharge plan, and Health Risk Assessment (HRA), if applicable, in the Member's current Plan of Care.

B. A CalOptima or Health Network case manager shall contact the LTC facility staff when appropriate to:

1. Request a Member's ICT meeting schedule;

2. Inform the LTC facility staff that the case manager would like to participate and obtain permission to attend Member's ICT;

3. Provide a copy of Member's completed HRA to the facility staff;

4. Provide additional resources and care coordination as appropriate; and

5. Document ICT participation and findings in the Member's Medical Record.

C. An LTC facility ICT case conference may include physician(s), nurse(s), therapist(s), social worker(s), and other health care professionals. The Members of the ICT shall contribute to and establish the written Plan of Care for a Member. The Plan of Care shall include, but is not limited to the following:

1. Diagnoses, symptoms, complaints, and complications;

2. Description of the functional and cognitive level of the Member;

3. Psychosocial status;

4. Caregiver involvement and support system;

5. Objectives for the Member during the facility stay;

6. Any orders for:

a. Medications;

b. Treatments;

c. Restorative and rehabilitative services;

d. Activities;

e. Therapies;

f. Social services;

g. Diet;

h. Special procedures recommended for the health and safety of the Member; and

i. Special procedures designed to meet the objectives of the Plan of Care;

7. Plans for continuing care, including review and modification of the Plan of Care;

8. Plans for discharge; and

9. Plans for leaves of absence, if applicable.

D. The attending physician, or Primary Care Provider (PCP), and other health care professional involved in the Member's care, shall review, discuss care goals with the Member and/or the Member's Authorized Representative, and sign each Plan of Care. In addition, the attending physician or PCP, and other personnel involved in the Member's care, must review, update as appropriate, and sign each Plan of Care at least every sixty (60) calendar days.

E. The Member or the Member's Authorized Representative must be offered their Plan of Care, as well as any amendments to it if applicable, by the LTC Facility staff. If assistance with translation is required, the LTC Facility or CalOptima can provide translation services as needed.

F. CalOptima LTSS, or Health Network staff, may review the Member's Plan of Care as a Member's health condition changes or to provide additional care coordination, including but not limited to Member events such as:

1. Visit(s) to the emergency room;

2. Admission(s) to an acute hospital;

3. Significant increases in Polypharmacy; and

4. Findings from Health Risk Assessments.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy CMC.6031: Health Risk Assessment
C. CalOptima Policy GG.1323: Seniors and Persons with Disabilities (SPD) Health Risk Assessment
D. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
E. Department of Health Care Services (DHCS) Duals Plan Letter (DPL) 14-002: Requirements for Nursing Facility Services.
F. Department of Health Care Services (DHCS) Dual Plan Letter (DPL) 16-003: Discharge Planning for Cal MediConnect
G. Medi-Cal Provider Manual: Patients Plans of Care for Long-Term Care
H. Title 22, California Code of Regulations (CCR), §§ 51118, 51120, 51121, 51124, 51164-51164.2, 51212, 51215, 51215.5, 51215.8, 51343(g), 51343.1(f), 51343.2(h), , , 76079, 76345 and 76853
I. Title 42, Code of Federal Regulations (CFR), §§ 456.80 and 456.380

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
05/26/2016	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/1996	GG.1808	Plan of Care, Long-Term Care	Medi-Cal
Revised	07/01/2007	GG.1808	Plan of Care, Long-Term Care	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.1808	Plan of Care, Long-Term Care	OneCare Connect
Revised	02/01/2016	GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect
Retired	03/08/2016	CMC.1808	Plan of Care, Long Term Care	OneCare Connect
Revised	10/01/2016	GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect
Revised	12/01/2017	GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect
Revised		GG.1808	Plan of Care, Long-Term Care	Medi-Cal OneCare Connect

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Subacute Facility-Adult	A health facility that meets the standards set forth in Title 22, Section 51215.5, as an identifiable unit of a SNF accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DPH for such purpose and has been certified by the DHCS for participation in the Medi-Cal program.
Subacute Facility-Pediatric	A health facility that meets the standards set forth in Title 22, Section 51215.8, as an identifiable unit of a certified nursing facility licensed as a SNF meeting the standards for participation as a provider under the Medi-Cal program, accommodating beds including contiguous rooms, a wing, a floor, or a building that is approved by the DHCS for such purpose.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of Modifications to CalOptima's Pharmacy Management Policies and Procedures

Contacts

Emily Fonda, M.D., Deputy Chief Medical Officer (714) 246-8400
Kris Gericke, Pharm.D., Director, Clinical Pharmacy Management (714) 246-8400

Recommended Action

Approve modifications to the following existing policies and procedures in connection with CalOptima's regular review process and consistent with regulatory requirements, as follows:

1. MA.6106 Medication Therapy Management [OneCare, OneCare Connect]
2. GG.1406 Pharmacy Network: Credentialing and Access [Medi-Cal, OneCare, OneCare Connect, PACE]
3. GG.1409 Drug Formulary Development and Management [Medi-Cal]
4. GG.1410 Appeal Process for Pharmacy Authorizations [Medi-Cal]
5. GG.1423 Medication Quality Assurance Program [Medi-Cal]

Background/ Discussion

CalOptima staff regularly reviews the organization's Policies and Procedures to ensure that they are up-to-date and aligned with Federal and State health care program requirements, contractual obligations and laws, as well as CalOptima operations.

Below is information regarding the policies that require modification and the proposed updates:
MA.6106 Medication Therapy Management [OneCare, OneCare Connect]: This policy defines CalOptima's Medication Therapy Management (MTM) program, in compliance with the Centers for Medicare & Medicaid Services (CMS) processes and standards. Recommended updates included revising cost thresholds as required in "CY 2020 Medication Therapy Management Program Guidance and Submission Instructions" and inclusion of expanded MTM eligibility criteria. The expanded eligibility criteria were derived from "Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019".

GG.1406 Pharmacy Network: Credentialing and Access [Medi-Cal, OneCare, OneCare Connect, PACE]: This policy establishes pharmacy credentialing and access standards and sets forth a procedure by which the Pharmacy Benefit Manager (PBM) determines if a pharmacy and its professional and technical staff meet credentialing standards and if members have appropriate geographic access to the participating pharmacy network. CalOptima staff proposes revising this policy pursuant to the CalOptima annual review process to remove references to credentialing requirements for Registered Nurses and Participating Pharmacies at community clinics to ensure alignment with current operations and regulatory requirements.

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GG.1409 Drug Formulary Development and Management [Medi-Cal]: This policy defines the process by which CalOptima develops and manages the drug Formulary. CalOptima staff proposes revising this policy pursuant to the CalOptima annual review process to incorporate references on how Members and Prescribing Practitioners, who do not have access to fax, email or internet, can receive a hard copy of CalOptima's Formulary.

GG.1410 Appeal Process for Pharmacy Authorizations [Medi-Cal]: This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service, or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory, and contractual requirements. CalOptima staff proposes revising this policy pursuant to the CalOptima annual review process to expand the appeal review by acquiring the service of a specialist health care professional consultant in the same or similar specialty that typically treats the Medical Condition and treating complications that may result from the service or procedure, as appropriate. In addition, minor changes were made to align the definition of expedited appeal with the 42 CFR 438.410 criteria.

GG.1423 Medication Quality Assurance Program [Medi-Cal]: This policy outlines the quality assurance program which is intended to reduce medication errors and adverse drug interactions, and improve medication use through prospective and retrospective Drug Utilization Review (DUR). CalOptima staff proposes revising this policy pursuant to the CalOptima annual review process to ensure alignment with current operations and regulatory requirements to include opioid DUR requirements and ensure compliance with CalOptima Policy HH.1107: Fraud, Waste, and Abuse Investigation and Reporting.

Fiscal Impact

The recommended action to revise existing CalOptima medical policies and procedures is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget approved by the Board on June 4, 2020.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt the proposed updates to the presented CalOptima policies and procedures. The updated policies and procedures will supersede the prior versions.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. MA.6106: Medication Therapy Management (Redlined and Clean versions)
2. GG.1406: Pharmacy Network: Credentialing and Access (Redlined and Clean versions)
3. GG.1409: Drug Formulary Development and Management (Redlined and Clean versions)
4. GG.1410: Appeal Process for Pharmacy Authorizations (Redlined and Clean versions)
5. GG.1423: Medication Quality Assurance Program (Redlined and Clean versions)

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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Policy:	MA.6106
Title:	**Medication Therapy Management**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/06
Revised Date:	~~10/01/18~~

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy defines CalOptima's Medication Therapy Management (MTM) program, in compliance with the Centers for Medicare & Medicaid Services (CMS) MTM processes and standards.

II. POLICY

A. On an annual basis, CalOptima shall develop an MTM program in cooperation with licensed and practicing Pharmacists and Providers.

B. CalOptima shall submit the MTM program description annually to CMS for review and approval during the appropriate MTM program submission window.

C. The MTM program includes elements to:

1. Promote and enhance Member understanding of the appropriate use of medications to optimize therapeutic outcomes.

2. Reduce the risk of potential adverse events, including adverse drug interactions, associated with medications through Member education, counseling, and other appropriate means.

3. Increase Member ~~medication adherence~~Medication Adherence with medication refill reminders, special packaging, and other case specific aids that will improve Members drug adherence.

4. Detect adverse drug events and patterns of medication utilization. This will include, but not be limited to overutilization, underutilization, suboptimal dosing, appropriateness of therapy, medications without a clear indication, identifying side effects related to drug therapy, polypharmacy, drug-drug interactions, drug-food interactions, and drug-disease interactions.

5. Coordinate with CalOptima's care management plan established for a targeted individual under a chronic care improvement program (CCIP).

D. CalOptima identifies Members eligible for the MTM program and shall provide MTM program services, in accordance with the provisions of this Policy.

E. CalOptima safeguards against discrimination based on the nature of MTM interventions (i.e., TTY if phone based, Braille if mail based, etc.).

F. CalOptima does not deny a Member's access to prescription drugs based on the Member's failure to participate in the MTM program.

G. CalOptima uses the MTM program to detect, evaluate, and resolve medication issues to ensure cost-effective medication use and the highest quality clinical outcomes for Members.

H. CalOptima reimburses ~~qualified~~Qualified Providers participating in the MTM program in accordance with the current program year's fee schedule. CalOptima lists the reimbursement rates in the annual CMS MTM program submission.

I. Upon request, CalOptima shall disclose to CMS the amount of the management and dispensing fees, and the portion paid for the MTM program services to CMS approved ~~qualified~~Qualified Providers. Such reports are protected under the provisions of Section 1927(b)(3)(D) of the Social Security Act.

J. The MTM program may distinguish between services in ambulatory and institutional settings. Where in institutional settings, the Comprehensive Medication Review (CMR) Provider may choose to meet the patient or caregiver at the Member's facility or complete the review telephonically.

K. CalOptima enrolls a Targeted Beneficiary using an opt-out method of enrollment only. CalOptima shall auto-enroll the Targeted Beneficiary each contract year when he or she meets the eligibility criteria, and he or she is considered enrolled, unless the Member declines enrollment or requests to be disenrolled by the opt-out methodology. CalOptima's presumption is the Member opts out for the applicable contract year unless the Member explicitly states the opt-out is permanent or requests not to be contacted again regarding MTM.

1. A Member enrolled in CalOptima's MTM program may refuse or decline services without having to disenroll from the MTM program.

2. Should an identified Member desire to permanently opt-out of the MTM program, CalOptima honors the request and does not re-target the Member in future contract years.

    a. If the Member actively seeks enrollment in the MTM program at a later time, CalOptima allows the Member to participate as long as he or she meets the necessary MTM requirements.

L. Opt-outs shall be recorded by CalOptima Pharmacy Staff or local ~~pharmacists~~Pharmacists as follows:

1. Opt-outs due to plan disenrollment will be documented with an opt-out date corresponding to the last date of plan eligibility.

2. Opt-out dates due to death will be documented with an opt-out date corresponding to the last date of plan eligibility in accordance with CMS PCUG Guidance, Chapter 2, 50.2.3.

3. Member-level opt-out requests shall be documented as the receipt date of the Member's written notification or date of the verbal request. If a verbal request is received by CalOptima's Customer Service Department, it shall be documented in the Customer Service call logging system and the Pharmacy Department notified of the opt-out. ~~In the event written documentation is received, it is subject to the record retention requirements.~~

M. CalOptima targets Members for enrollment in the MTM program at least quarterly during each year according to the CMS approved MTM program methodology.

N. CalOptima offers a CMR to all Members enrolled in the MTM Program at least annually, and this includes Members who are in a ~~long term care~~Long-Term Care (LTC) setting.

O. CalOptima's MTM services are furnished by a ~~pharmacist~~Pharmacist or other ~~qualified provider~~Qualified Provider.

P. CalOptima shall not make any positive or negative changes to the approved MTM program within a given contract year without first receiving approval by CMS.

Q. All MTM documentation is subject to the record retention requirements outlined in the Medicare Managed Care Manual Chapter 11: 100.4.

III. PROCEDURE

A. Member Identification and Targeting

1. Targeted Beneficiaries. CalOptima identifies Members eligible for enrollment in the MTM program based on the following criteria:

   a. Member is receiving Part D medications to treat three (3) or more of the following core chronic conditions:

      i. Diabetes;

      ii. Respiratory Disease-Asthma;

      iii. Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD);

      iv. Hypertension;

      v. Dyslipidemia; or

      vi. End Stage Renal Disease (ESRD).

   b. Member is receiving eight (8) or more Part D medications per quarter; and

   c. Member is likely to incur annual costs for Covered Part D Drugs that exceed a dollar threshold prescribed by CMS; for CY ~~2019~~2020 the threshold is $4,~~044~~255.00.

      i. CalOptima calculates the total pharmacy claims for a Member on a quarterly basis.

      ii. CalOptima considers a Member as likely to incur an annual cost of $4,~~044~~255.00 if the Member has $1,~~011.00~~063.75 or more in paid claims for the quarter being evaluated.

2. On a quarterly basis, CalOptima's Pharmacy Management Department identifies Members who meet the criteria for inclusion in the MTM program through pharmacy and medical claims data. Medical claims analysis is limited to specific disease states as determined appropriate by CalOptima Pharmacy Department.

   a. Current disease states supported by a combination of medical claims or pharmacy

claims: End Stage Renal Disease.

b. Expanded Internal Eligibility Criteria. MTM services are also offered to Members who meet Expanded Internal Eligibility Criteria based on the Part D Drug Management Program for high-risk beneficiaries. Identified Members receive the same CMRs, TMRs, and interventions that Members who meet the specified criteria per CMS requirements receive. All aspects of the MTM program apply to this population.

i. Members are identified for the Drug Management Program at minimum quarterly utilizing the minimum Overutilization Monitoring System (OMS) criteria for calendar year 2020:

a) A look back period of the previous six (6) months; and

b) Member prescription exceeded an average daily morphine milligram equivalent (MME) of ninety (90) milligrams (mg) for any duration; and

1) Filled prescriptions written by three (3) or more Opioid prescribers and at three (3) or more pharmacies; or

2) Filled prescriptions written by five (5) or more Opioid prescribers, regardless of the number of Opioid dispensing pharmacies.

ii. Members excluded from the Drug Management Program, who will therefore not be identified for MTM based on Drug Management Program involvement, shall include:

a) Members being treated for active cancer-related pain;

b) Members receiving hospice, palliative, or end-of-life care;

c) Members residing in a long-term care facility, a facility described in section 1905(d) of the Act, or another facility for which frequently Abused drugs are dispensed for residents through a contract with a single pharmacy.

3. CalOptima notifies a Member who qualifies for the MTM program by sending ~~a~~an MTM invitation letter via United States (U.S.) mail.

a. Qualified Members are auto- enrolled into the CalOptima MTM program and will remain enrolled through the contract year unless the Member opts out of the MTM program entirely.

b. Qualified Members may opt-out from all or parts of the MTM program (TMR, CMR).

c. In addition to invitation letters, CalOptima conducts phone outreaches to qualified Members to increase CMR participation as a second approach to offer MTM services.

B. Services provided in the MTM program include, but are not limited to:

1. Offering a face-to-face or telephonic ~~comprehensive medication review (~~CMR~~)~~ at least annually by a ~~qualified~~Qualified Provider as indicated in the current year's MTM program submission to CMS. CMRs will include an interactive and comprehensive review of a Member's over-the-counter (OTC) medications, vitamin/herbal/dietary supplements, and prescription medications.

Qualified Providers shall provide a summary of the results of the CMR to the Member in CMS' standardized format within fourteen (14) calendar days of the completed CMR.

a. When the CMR is performed by CalOptima staff or local ~~pharmacists~~Pharmacists, CalOptima will print and mail the CMR documents in accordance with the Facilities Department mailroom procedure and CalOptima policy, as appropriate.

b. CalOptima offers the CMR to newly targeted Members within sixty (60) calendar days after being enrolled in the MTM program.

c. For Members enrolled in MTM the previous contract year who continue to meet criteria in the current contract year, the CMR is offered within one (1) year (i.e., 365 days) of the last CMR offer.

d. If the Member is offered the annual CMR and is unable to accept the offer to participate, the ~~pharmacist~~Pharmacist or other Qualified Provider as defined in the current contract year's CMS-approved MTM program may perform the CMR with the Member's prescriber, caregiver or other authorized individual.

e. For cognitively impaired Members, CalOptima reaches out to the Member's prescriber, caregiver or other authorized individual to complete the CMR. This applies to Members in all settings, including ~~long term care (~~LTC~~).~~.

i. CalOptima's Pharmacy Management Department collects documentation and/or will provide rationale when making the determination that a Member is cognitively impaired and unable to participate in the CMR.

f. CalOptima recognizes the challenges of performing CMRs in the ~~Long Term Care (~~LTC~~)~~ setting and engages ~~qualified~~Qualified Providers to perform the CMR who have experience engaging Members, prescribers and ancillary health care professionals in the LTC setting.

i. Where possible, CalOptima coordinates MTM activities with the care plan meeting to assess current regimens.

2. Formulation of a Medication Action Plan (MAP);

3. Formulation of a Personal Medication List (PML);

4. Evaluation and monitoring of a Member's response to drug therapy;

5. Coordination of medication therapy with other care management services, such as case management; and

6. Performing quarterly ~~targeted medication reviews (TMRs).~~TMRs. TMRs systematically look for drug therapy issues. CalOptima's MTM vendor provides outreach to prescribers via fax in accordance with the methodologies outlined in MTM vendor's policy, CLOP_~~044b~~044, as referenced herein. Educational newsletters are mailed to Members who are in the program. Also, follow-up interventions will be provided, if necessary, for all Members enrolled in the MTM program.

a. If a Member declines the annual CMR, CalOptima still offers interventions to the prescriber and performs TMRs at least quarterly to assess medication use on an on-going basis.

b. CalOptima performs TMR interventions to the beneficiary's prescribers irrespective of the CMR acceptance or completion.

7. On a quarterly basis, CalOptima's Pharmacy Management Department shall:

a. Notify a Member's Primary Care Provider (PCP) of the Member's participation in the MTM program to ensure coordination between the MTM program and the care provided by the PCP; and

b. Provide a list of Members participating in the MTM program to the CalOptima Case Management Department to ensure coordination between the MTM program and the Medicare chronic care improvement program (CCIP) under Section 1807 of the Social Security Act.

C. While offering the CMR, the ~~qualified~~Qualified Provider shall:

1. Review the Member's medication profile with respect to:

a. Therapeutic duplication;

b. Appropriateness of therapy, including medically accepted indications (MAI);

c. Appropriateness of dosing;

d. Drug to drug interactions;

e. Drug to disease interactions;

f. Contraindications;

g. Adverse effects;

h. Subtherapeutic response; and

i. Overutilization as evidenced by:

i. Controlled substances, especially opiates;

ii. Excessive quantities; or

iii. High doses.

2. Underutilization as evidenced by:

a. Poor adherence; or

b. Subtherapeutic dose.

3. Potential Fraud and Abuse;

4. Multiple prescribers; and

5. Other parameters as determined by the ~~qualified~~Qualified Provider on a case-by-case basis.

   a. Provide individual education to the Member regarding appropriate medication use;

   b. Utilize interventions to improve adherence to prescribed medication regimens, such as directed counseling, special packaging, or refill reminders; and

   c. Contact the Member's Prescriber, as necessary, to recommend changes to the medication regimen.

D. Billing for local ~~pharmacist~~Pharmacist and LTC ~~pharmacist~~Pharmacist provided MTM services shall be done using MTM Current Procedural Terminology (CPT) codes appropriate for the type and length of service provided. MTM CPT codes listed in the following table:

MTM CPT Codes

CPT Code	Description	Reimbursement Rate
99605	MTM service(s) provided by a ~~pharmacist~~Pharmacist to an individual patient during a face-to-face encounter that involve an assessment and intervention if provided; used to code the initial fifteen (15) minutes of an initial encounter with a new MTM patient	$25
99606	Initial fifteen (15) minutes with an established patient	$25
99607	Each additional fifteen (15) minutes of an initial or subsequent MTM encounter; list separately in addition to code for primary service and in conjunction with 99605 or 99606	$25

E. CalOptima's Pharmacy Management Department shall measure the effectiveness of the MTM program through:

1. High risk medication utilization;

2. The number of physician-accepted drug therapy recommendations;

3. Annual pharmacy expenditures per Member;

4. Member satisfaction surveys; and

5. ~~Number~~The number of ~~Drug Therapy Resolutions not~~drug therapy resolutions other than physician-accepted recommendations, such as ~~Medication Adherence~~medication adherence.

F. CalOptima shall report to CMS specific data on the MTM program in the manner prescribed by CMS. CalOptima shall report information annually related to the implementation of the MTM program that may include, but is not limited to:

1. Number of Members identified for the MTM program;

2. Number of Members participating in the MTM program;

3. Number of Members who are eligible, but declined participation in the MTM program; and

4. Total drug cost for Members in MTM on a per MTM-enrolled Member per month basis.

G. CalOptima increases Member awareness about the MTM program and promotes its value by ensuring Customer Service representatives and staff are trained and familiar with the MTM program.

1. CalOptima loads MTM eligibility into the Customer Service call system which provides eligibility information to Customer Service representatives.

H. CalOptima also includes a separate section on MTM on their website that includes:

1. CalOptima's specific MTM program eligibility requirements;

2. A statement informing Members who to contact at CalOptima for more information, with customer service personnel prepared to answer questions about the MTM program;

3. High-level summary of services offered as part of the MTM program;

4. A statement explaining the purpose and benefits of MTM, and that it is a free service for eligible Members;

5. A description of how the Member will be notified by CalOptima that they are eligible and enrolled in the MTM program;

6. Statements on how Members will be contacted and offered services by CalOptima, including the CMR and TMR, and a description of how the reviews are conducted and delivered, including time commitments and materials Members will receive;

7. A statement on how the Member may obtain MTM service documents, including a blank copy of the Personal Medication List posted on the website; and

8. A statement clarifying that the MTM Program is not considered a benefit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
~~B.~~A. ~~California Business and Professions Code, §4040~~
~~C.~~B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
~~D.~~C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
~~E.~~D. CMS Prescription Drug Benefit Manual, Chapter 7 – Medication Therapy Management and Quality Improvement Program, Revised 02/19/2010
~~F.~~E. "CY ~~2019~~2020 Medication Therapy Management Program Guidance and Submission Instructions," Health Plan Management System (HPMS) Memorandum, Issued 04/~~06/2018~~05/2019
~~G.~~F. CMS PCUG Guidance, Chapter 2, 50.2.3
~~H.~~G. Medicare Managed Care Manual Chapter 11: 100.4
~~I.~~H. Medicare Modernization Act, Section 1860D-4(c)(2)

~~J.~~I. Pharmacy Services Program Manual "Revisions to the Medicare Part D Medication Therapy Management Program Standardized Format." Health Plan Management System (HPMS) Memorandum, Issued 08/29/2017

J. California Business and Professions Code, §4040

K. Social Security Act, §1807

L. Title 42, Code of Federal Regulations (CFR), §423.153(d)(e)

M. Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019

~~M.~~N. MTM Vendor ~~Policies:~~

a. Provider Faxing Policy #CLOP_~~044b~~044

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

~~Version~~ Action	Date	Policy ~~Number~~	Policy Title	~~Line~~Program(s) ~~of Business~~
Effective	01/01/2006	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2008	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2011	MA.6106	Medication Therapy Management	OneCare
Revised	01/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	05/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	10/01/2014	MA.6106	Medication Therapy Management	OneCare
Revised	06/01/2015	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	07/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	11/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	12/01/2017	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	02/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	10/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	TBD	MA.6106	Medication Therapy Management	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare program. ~~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 fraudFraud, because the distinction between "fraudFraud" and "abuseAbuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.~~ OneCare Connect: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare Connect program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare Connect program. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Comprehensive Medication Review (CMR)	A process of collecting Member-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the Member, caregiver and/or prescriber. It is designed to improve Member's knowledge of their prescriptions, OTC medications, identify and address problems or concerns the Member may have, and empower Members to self-manage their medications and health conditions.
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.

Term	Definition
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Expanded Internal Eligibility Criteria	Additional criteria selected and determined by the plan. All MTM services offered to enrollees who meet the specified targeting criteria per CMS requirements must also be offered to those meeting the expanded internal eligibility criteria.
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i). ~~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 fraudulentFraudulent 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 Section 1347).~~
Long Term Care	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Medication Adherence	The extent to which a person takes medications as prescribed by their health care ~~providers~~Providers.
Medication Therapy Management (MTM)	A program of drug therapy management furnished by a ~~pharmacist~~Pharmacist and that is designed to: 1. Assure that Covered Part D Drugs are appropriately used to optimize therapeutic outcomes through improved medication use; and 2. Reduce the risk of adverse events, including adverse drug interactions.
Member	A~~n enrollee~~ beneficiary ~~of~~ enrolled in a CalOptima~~the OneCare or OneCare Connect~~ program.
Over-the Counter (OTC)	Defined as products available for purchase without a prescription.
Pharmacist	A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.~~A physician who focuses his or her practice of medicine to general practice or who is a board certified or board eligible internist, pediatrician, obstetrician/gynecologist, or family practitioner. The PCP is responsible for supervising, coordinating, and providing initial and primary care to Members, initiating referrals, and maintaining the continuity of Member care under OneCare or OneCare Connect.~~

Term	Definition
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.~~A physician, pharmacist~~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.~~
Qualified Provider	An individual who completes the Interactive, person-to-person Comprehensive Medication Review (CMR) with written summaries as defined in the current MTM Program approved by CMS.
Targeted Beneficiary	A CalOptima Member who meets the eligibility criteria of the MTM program, which includes having at least three (3) qualifying core chronic diseases, is taking eight (8) or more Part D medications per quarter, and one who is likely to incur annual costs for ~~covered~~Covered Part D ~~drugs~~Drugs greater than or equal to the MTM annual cost threshold as further identified in this Policy.
Targeted Medication Review (TMR)	~~The TMR is distinct from a CMR because it is~~A review focused on specific or potential medication-related problems. ~~-~~The identified problem is communicated directly to the Member's prescriber~~.~~

1

Policy:	MA.6106
Title:	**Medication Therapy Management**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	01/01/06
Revised Date:	

Applicable to:

- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy defines CalOptima's Medication Therapy Management (MTM) program, in compliance with the Centers for Medicare & Medicaid Services (CMS) MTM processes and standards.

II. POLICY

A. On an annual basis, CalOptima shall develop an MTM program in cooperation with licensed and practicing Pharmacists and Providers.

B. CalOptima shall submit the MTM program description annually to CMS for review and approval during the appropriate MTM program submission window.

C. The MTM program includes elements to:

1. Promote and enhance Member understanding of the appropriate use of medications to optimize therapeutic outcomes.

2. Reduce the risk of potential adverse events, including adverse drug interactions, associated with medications through Member education, counseling, and other appropriate means.

3. Increase Member Medication Adherence with medication refill reminders, special packaging, and other case specific aids that will improve Members drug adherence.

4. Detect adverse drug events and patterns of medication utilization. This will include, but not be limited to overutilization, underutilization, suboptimal dosing, appropriateness of therapy, medications without a clear indication, identifying side effects related to drug therapy, polypharmacy, drug-drug interactions, drug-food interactions, and drug-disease interactions.

5. Coordinate with CalOptima's care management plan established for a targeted individual under a chronic care improvement program (CCIP).

D. CalOptima identifies Members eligible for the MTM program and shall provide MTM program services, in accordance with the provisions of this Policy.

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E. CalOptima safeguards against discrimination based on the nature of MTM interventions (i.e., TTY if phone based, Braille if mail based, etc.).

F. CalOptima does not deny a Member's access to prescription drugs based on the Member's failure to participate in the MTM program.

G. CalOptima uses the MTM program to detect, evaluate, and resolve medication issues to ensure cost-effective medication use and the highest quality clinical outcomes for Members.

H. CalOptima reimburses Qualified Providers participating in the MTM program in accordance with the current program year's fee schedule. CalOptima lists the reimbursement rates in the annual CMS MTM program submission.

I. Upon request, CalOptima shall disclose to CMS the amount of the management and dispensing fees, and the portion paid for the MTM program services to CMS approved Qualified Providers. Such reports are protected under the provisions of Section 1927(b)(3)(D) of the Social Security Act.

J. The MTM program may distinguish between services in ambulatory and institutional settings. Where in institutional settings, the Comprehensive Medication Review (CMR) Provider may choose to meet the patient or caregiver at the Member's facility or complete the review telephonically.

K. CalOptima enrolls a Targeted Beneficiary using an opt-out method of enrollment only. CalOptima shall auto-enroll the Targeted Beneficiary each contract year when he or she meets the eligibility criteria, and he or she is considered enrolled, unless the Member declines enrollment or requests to be disenrolled by the opt-out methodology. CalOptima's presumption is the Member opts out for the applicable contract year unless the Member explicitly states the opt-out is permanent or requests not to be contacted again regarding MTM.

1. A Member enrolled in CalOptima's MTM program may refuse or decline services without having to disenroll from the MTM program.

2. Should an identified Member desire to permanently opt-out of the MTM program, CalOptima honors the request and does not re-target the Member in future contract years.

    a. If the Member actively seeks enrollment in the MTM program at a later time, CalOptima allows the Member to participate as long as he or she meets the necessary MTM requirements.

L. Opt-outs shall be recorded by CalOptima Pharmacy Staff or local Pharmacists as follows:

1. Opt-outs due to plan disenrollment will be documented with an opt-out date corresponding to the last date of plan eligibility.

2. Opt-out dates due to death will be documented with an opt-out date corresponding to the last date of plan eligibility in accordance with CMS PCUG Guidance, Chapter 2, 50.2.3.

3. Member-level opt-out requests shall be documented as the receipt date of the Member's written notification or date of the verbal request. If a verbal request is received by CalOptima's Customer Service Department, it shall be documented in the Customer Service call logging system and the Pharmacy Department notified of the opt-out.

M. CalOptima targets Members for enrollment in the MTM program at least quarterly during each year according to the CMS approved MTM program methodology.

N. CalOptima offers a CMR to all Members enrolled in the MTM Program at least annually, and this includes Members who are in a Long-Term Care (LTC) setting.

O. CalOptima's MTM services are furnished by a Pharmacist or other Qualified Provider.

P. CalOptima shall not make any positive or negative changes to the approved MTM program within a given contract year without first receiving approval by CMS.

Q. All MTM documentation is subject to the record retention requirements outlined in the Medicare Managed Care Manual Chapter 11: 100.4.

III. PROCEDURE

A. Member Identification and Targeting

1. Targeted Beneficiaries. CalOptima identifies Members eligible for enrollment in the MTM program based on the following criteria:

   a. Member is receiving Part D medications to treat three (3) or more of the following core chronic conditions:

      i. Diabetes;

      ii. Respiratory Disease-Asthma;

      iii. Respiratory Disease-Chronic Obstructive Pulmonary Disease (COPD);

      iv. Hypertension;

      v. Dyslipidemia; or

      vi. End Stage Renal Disease (ESRD).

   b. Member is receiving eight (8) or more Part D medications per quarter; and

   c. Member is likely to incur annual costs for Covered Part D Drugs that exceed a dollar threshold prescribed by CMS; for CY 2020 the threshold is $4,255.00.

      i. CalOptima calculates the total pharmacy claims for a Member on a quarterly basis.

      ii. CalOptima considers a Member as likely to incur an annual cost of $4,255.00 if the Member has $1,063.75 or more in paid claims for the quarter being evaluated.

2. On a quarterly basis, CalOptima's Pharmacy Management Department identifies Members who meet the criteria for inclusion in the MTM program through pharmacy and medical claims data. Medical claims analysis is limited to specific disease states as determined appropriate by CalOptima Pharmacy Department.

   a. Current disease states supported by a combination of medical claims or pharmacy claims: End Stage Renal Disease.

   b. Expanded Internal Eligibility Criteria. MTM services are also offered to Members who

meet Expanded Internal Eligibility Criteria based on the Part D Drug Management Program for high-risk beneficiaries. Identified Members receive the same CMRs, TMRs, and interventions that Members who meet the specified criteria per CMS requirements receive. All aspects of the MTM program apply to this population.

i. Members are identified for the Drug Management Program at minimum quarterly utilizing the minimum Overutilization Monitoring System (OMS) criteria for calendar year 2020:

a) A look back period of the previous six (6) months; and

b) Member prescription exceeded an average daily morphine milligram equivalent (MME) of ninety (90) milligrams (mg) for any duration; and

1) Filled prescriptions written by three (3) or more Opioid prescribers and at three (3) or more pharmacies; or

2) Filled prescriptions written by five (5) or more Opioid prescribers, regardless of the number of Opioid dispensing pharmacies.

ii. Members excluded from the Drug Management Program, who will therefore not be identified for MTM based on Drug Management Program involvement, shall include:

a) Members being treated for active cancer-related pain;

b) Members receiving hospice, palliative, or end-of-life care;

c) Members residing in a long-term care facility, a facility described in section 1905(d) of the Act, or another facility for which frequently Abused drugs are dispensed for residents through a contract with a single pharmacy.

3. CalOptima notifies a Member who qualifies for the MTM program by sending an MTM invitation letter via United States (U.S.) mail.

a. Qualified Members are auto enrolled into the CalOptima MTM program and will remain enrolled through the contract year unless the Member opts out of the MTM program entirely.

b. Qualified Members may opt-out from all or parts of the MTM program (TMR, CMR).

c. In addition to invitation letters, CalOptima conducts phone outreaches to qualified Members to increase CMR participation as a second approach to offer MTM services.

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1. Offering a face-to-face or telephonic CMR at least annually by a Qualified Provider as indicated in the current year's MTM program submission to CMS. CMRs will include an interactive and comprehensive review of a Member's over-the-counter (OTC) medications, vitamin/herbal/dietary supplements, and prescription medications. Qualified Providers shall provide a summary of the results of the CMR to the Member in CMS' standardized format within fourteen (14) calendar days of the completed CMR.

a. When the CMR is performed by CalOptima staff or local Pharmacists, CalOptima will print and mail the CMR documents in accordance with the Facilities Department mailroom procedure and CalOptima policy, as appropriate.

b. CalOptima offers the CMR to newly targeted Members within sixty (60) calendar days after being enrolled in the MTM program.

c. For Members enrolled in MTM the previous contract year who continue to meet criteria in the current contract year, the CMR is offered within one (1) year (i.e., 365 days) of the last CMR offer.

d. If the Member is offered the annual CMR and is unable to accept the offer to participate, the Pharmacist or other Qualified Provider as defined in the current contract year's CMS-approved MTM program may perform the CMR with the Member's prescriber, caregiver or other authorized individual.

e. For cognitively impaired Members, CalOptima reaches out to the Member's prescriber, caregiver or other authorized individual to complete the CMR. This applies to Members in all settings, including LTC.

i. CalOptima's Pharmacy Management Department collects documentation and/or will provide rationale when making the determination that a Member is cognitively impaired and unable to participate in the CMR.

f. CalOptima recognizes the challenges of performing CMRs in the LTC setting and engages Qualified Providers to perform the CMR who have experience engaging Members, prescribers and ancillary health care professionals in the LTC setting.

i. Where possible, CalOptima coordinates MTM activities with the care plan meeting to assess current regimens.

2. Formulation of a Medication Action Plan (MAP);

3. Formulation of a Personal Medication List (PML);

4. Evaluation and monitoring of a Member's response to drug therapy;

5. Coordination of medication therapy with other care management services, such as case management; and

6. Performing quarterly TMRs. TMRs systematically look for drug therapy issues. CalOptima's MTM vendor provides outreach to prescribers via fax in accordance with the methodologies outlined in MTM vendor's policy, CLOP_044, as referenced herein. Educational newsletters are mailed to Members who are in the program. Also, follow-up interventions will be provided, if necessary, for all Members enrolled in the MTM program.

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7. On a quarterly basis, CalOptima's Pharmacy Management Department shall:

a. Notify a Member's Primary Care Provider (PCP) of the Member's participation in the MTM program to ensure coordination between the MTM program and the care provided by the PCP; and

b. Provide a list of Members participating in the MTM program to the CalOptima Case Management Department to ensure coordination between the MTM program and the Medicare chronic care improvement program (CCIP) under Section 1807 of the Social Security Act.

C. While offering the CMR, the Qualified Provider shall:

1. Review the Member's medication profile with respect to:

a. Therapeutic duplication;

b. Appropriateness of therapy, including medically accepted indications (MAI);

c. Appropriateness of dosing;

d. Drug to drug interactions;

e. Drug to disease interactions;

f. Contraindications;

g. Adverse effects;

h. Subtherapeutic response; and

i. Overutilization as evidenced by:

i. Controlled substances, especially opiates;

ii. Excessive quantities; or

iii. High doses.

2. Underutilization as evidenced by:

a. Poor adherence; or

b. Subtherapeutic dose.

3. Potential Fraud and Abuse;

4. Multiple prescribers; and

5. Other parameters as determined by the Qualified Provider on a case-by-case basis.

a. Provide individual education to the Member regarding appropriate medication use;

b. Utilize interventions to improve adherence to prescribed medication regimens, such as directed counseling, special packaging, or refill reminders; and

c. Contact the Member's Prescriber, as necessary, to recommend changes to the medication regimen.

D. Billing for local Pharmacist and LTC Pharmacist provided MTM services shall be done using MTM Current Procedural Terminology (CPT) codes appropriate for the type and length of service provided. MTM CPT codes listed in the following table:

MTM CPT Codes

CPT Code	Description	Reimbursement Rate
99605	MTM service(s) provided by a Pharmacist to an individual patient during a face-to-face encounter that involve an assessment and intervention if provided; used to code the initial fifteen (15) minutes of an initial encounter with a new MTM patient	$25
99606	Initial fifteen (15) minutes with an established patient	$25
99607	Each additional fifteen (15) minutes of an initial or subsequent MTM encounter; list separately in addition to code for primary service and in conjunction with 99605 or 99606	$25

E. CalOptima's Pharmacy Management Department shall measure the effectiveness of the MTM program through:

1. High risk medication utilization;

2. The number of physician-accepted drug therapy recommendations;

3. Annual pharmacy expenditures per Member;

4. Member satisfaction surveys; and

5. The number of drug therapy resolutions other than physician-accepted recommendations, such as medication adherence.

F. CalOptima shall report to CMS specific data on the MTM program in the manner prescribed by CMS. CalOptima shall report information annually related to the implementation of the MTM program that may include, but is not limited to:

1. Number of Members identified for the MTM program;

2. Number of Members participating in the MTM program;

3. Number of Members who are eligible, but declined participation in the MTM program; and

4. Total drug cost for Members in MTM on a per MTM-enrolled Member per month basis.

G. CalOptima increases Member awareness about the MTM program and promotes its value by ensuring Customer Service representatives and staff are trained and familiar with the MTM

program.

1. CalOptima loads MTM eligibility into the Customer Service call system which provides eligibility information to Customer Service representatives.

H. CalOptima also includes a separate section on MTM on their website that includes:

1. CalOptima's specific MTM program eligibility requirements;

2. A statement informing Members who to contact at CalOptima for more information, with customer service personnel prepared to answer questions about the MTM program;

3. High-level summary of services offered as part of the MTM program;

4. A statement explaining the purpose and benefits of MTM, and that it is a free service for eligible Members;

5. A description of how the Member will be notified by CalOptima that they are eligible and enrolled in the MTM program;

6. Statements on how Members will be contacted and offered services by CalOptima, including the CMR and TMR, and a description of how the reviews are conducted and delivered, including time commitments and materials Members will receive;

7. A statement on how the Member may obtain MTM service documents, including a blank copy of the Personal Medication List posted on the website; and

8. A statement clarifying that the MTM Program is not considered a benefit.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Applications from Medicare Advantage Prescription Drug Plans (MA-PD) Sponsors
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. CMS Prescription Drug Benefit Manual, Chapter 7 – Medication Therapy Management and Quality Improvement Program, Revised 02/19/2010
E. "CY 2020 Medication Therapy Management Program Guidance and Submission Instructions," Health Plan Management System (HPMS) Memorandum, Issued 04/05/2019
F. CMS PCUG Guidance, Chapter 2, 50.2.3
G. Medicare Managed Care Manual Chapter 11: 100.4
H. Medicare Modernization Act, Section 1860D-4(c)(2)
I. Pharmacy Services Program Manual "Revisions to the Medicare Part D Medication Therapy Management Program Standardized Format." Health Plan Management System (HPMS) Memorandum, Issued 08/29/2017
J. California Business and Professions Code, §4040
K. Social Security Act, §1807
L. Title 42, Code of Federal Regulations (CFR), §423.153(d)(e)

M. Improving Drug Utilization Review Controls in Part D, CY 2020 Final Call Letter: April 1, 2019
N. MTM Vendor
    a. Provider Faxing Policy #CLOP_044

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2006	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2008	MA.6106	Medication Therapy Management	OneCare
Revised	02/01/2011	MA.6106	Medication Therapy Management	OneCare
Revised	01/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	05/01/2012	MA.6106	Medication Therapy Management	OneCare
Revised	10/01/2014	MA.6106	Medication Therapy Management	OneCare
Revised	06/01/2015	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	07/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	11/01/2016	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	12/01/2017	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	02/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	10/01/2018	MA.6106	Medication Therapy Management	OneCare OneCare Connect
Revised	TBD	MA.6106	Medication Therapy Management	OneCare OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	OneCare: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare program. OneCare Connect: A Provider practice that is inconsistent with sound fiscal, business, or medical practice, and results in an unnecessary cost to CalOptima and the OneCare Connect program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to CalOptima and the OneCare Connect program. Or the intentional or careless act that causes harm or serious risk of harm to an older person or vulnerable adult, including physical abuse, emotional abuse, sexual abuse, and exploitation, neglect, abandonment or self-neglect.
Centers for Medicare & Medicaid Services (CMS)	The federal agency under the United States Department of Health and Human Services responsible for administering the Medicare and Medicaid programs.
Comprehensive Medication Review (CMR)	A process of collecting Member-specific information, assessing medication therapies to identify medication-related problems, developing a prioritized list of medication-related problems, and creating a plan to resolve them with the Member, caregiver and/or prescriber. It is designed to improve Member's knowledge of their prescriptions, OTC medications, identify and address problems or concerns the Member may have, and empower Members to self-manage their medications and health conditions.
Covered Part D Drug	A Covered Part D Drug includes: 1. A drug that may be dispensed only upon a Prescription, approved by the Food and Drug Administration (FDA), used and sold in the United States, and used for a medically accepted indication as set forth in Section 1927(k)(2)(A) of the Social Security Act; 2. A biological product described in sections 1927(k)(2)(B)(i) through (iii) of the Social Security Act; 3. Insulin described in section 1927(k)(2)(C) of the Social Security Act; 4. Medical supplies associated with the delivery of insulin; and 5. A vaccine licensed under section 351 of the Public Health Service Act and its administration.
End Stage Renal Disease (ESRD)	That stage of kidney impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplantation to maintain life. End Stage Renal Disease is classified as Stage V of Chronic Kidney Disease. This stage exists when renal function, as measured by glomerular filtration rate (GFR), is less than 15ml/min/1.73m^2 and serum creatinine is greater than or equal to eight, unless the Member is diabetic, in which case serum creatinine is greater than or equal to six (6). Excretory, regulatory, and hormonal renal functions are severely impaired, and the Member cannot maintain homeostasis.
Expanded Internal Eligibility Criteria	Additional criteria selected and determined by the plan. All MTM services offered to enrollees who meet the specified targeting criteria per CMS requirements must also be offered to those meeting the expanded internal eligibility criteria.

Term	Definition
Fraud	An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit_to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law, in accordance with Title 42 Code of Federal Regulations section 455.2, Welfare and Institutions Code section 14043.1(i).
Long Term Care	A variety of services that help Members with health or personal needs and Activities of Daily Living over a period of time. Long Term Care (LTC) may be provided at home, in the community, or in various types of facilities, including nursing homes and assisted living facilities.
Medication Adherence	The extent to which a person takes medications as prescribed by their health care Providers.
Medication Therapy Management (MTM)	A program of drug therapy management furnished by a Pharmacist and that is designed to: 1. Assure that Covered Part D Drugs are appropriately used to optimize therapeutic outcomes through improved medication use; and 2. Reduce the risk of adverse events, including adverse drug interactions.
Member	A beneficiary enrolled in a CalOptima program.
Over-the Counter (OTC)	Defined as products available for purchase without a prescription.
Pharmacist	A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy.
Primary Care Provider (PCP)	A person responsible for supervising, coordinating, and providing initial and primary care to patients; for initiating referrals; and for maintaining the continuity of patient care. A PCP may be a physician or non-physician medical practitioner.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.
Qualified Provider	An individual who completes the Interactive, person-to-person Comprehensive Medication Review (CMR) with written summaries as defined in the current MTM Program approved by CMS.
Targeted Beneficiary	A CalOptima Member who meets the eligibility criteria of the MTM program, which includes having at least three (3) qualifying core chronic diseases, is taking eight (8) or more Part D medications per quarter, and one who is likely to incur annual costs for Covered Part D Drugs greater than or equal to the MTM annual cost threshold as further identified in this Policy.
Targeted Medication Review (TMR)	A review focused on specific or potential medication-related problems. The identified problem is communicated directly to the Member's prescriber.

1

Policy #:	GG.1406Δ
Title:	**Pharmacy Network: Credentialing and Access**
Department:	Medical ~~Affairs~~Management
Section:	Pharmacy Management
CEO Approval:	~~Michael Schrader~~
Effective Date:	03/01/99
Last Revised Date:	~~10/01/18~~
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes Pharmacy credentialing and access standards and to set forth a procedure by which the Pharmacy Benefit Manager (PBM) shall determine if a Pharmacy and its professional and technical staff meet credentialing standards and if Members have appropriate geographic access to the Participating Pharmacy Network.

II. POLICY

A. Credentialing Standards

1. CalOptima shall establish credentialing standards, as set forth herein, and review those standards periodically.

2. CalOptima may delegate the process for credentialing and recredentialing each Pharmacy and its professional and technical staff to a Pharmacy Benefit Manager (PBM) through a written agreement.

3. Each Participating Pharmacy and its professional and technical staff shall meet CalOptima's credentialing standards and shall be credentialed prior to entering into a Participating Pharmacy Agreement (PPA) and recredentialed every two (2) years thereafter.

4. ~~All~~All peer review and quality assessment reports and Records produced and obtained pursuant to this ~~policy~~Policy shall be governed by California Welfare and Institutions Code, Section 14087.58(b), and California Evidence Code, Section 1157.

5. CalOptima shall provide oversight of the credentialing and recredentialing process, including conducting an annual Audit of the PBM's credentialing process to ensure compliance with the standards set forth herein.

B. Access Standards

1. CalOptima shall ensure that each Member has access to Pharmaceutical Services as follows:

   a. At least ninety percent (90%) of Members, on average, in urban areas live within two (2) miles of a Participating Pharmacy;

b. At least ninety percent (90%) of Members, on average, in suburban areas live within five (5) miles of a Participating Pharmacy; and

c. At least seventy percent (70%) of Members, on average, in rural areas live within fifteen (15) miles of a Participating Pharmacy.

2. Members shall have access to network pharmacies within ten (10) miles or thirty (30) minutes of their residence.

3. CalOptima may delegate the responsibility for determining whether or not access standards are met to the PBM.

C. Participation in Participating Pharmacy Network

1. Before providing Pharmaceutical Services to a Member, a Pharmacy that meets the terms and conditions of the PPA and credentialing standards shall sign the most current version of the PPA.

2. A signed PPA with a Chain Pharmacy shall be applicable to the individually licensed locations of that Chain Pharmacy that meet the credentialing standards set forth herein.

3. If a Pharmacy had been eligible, but chose not, to participate in the Participating Pharmacy Network between January 1, 2005, and December 31, 2005, such Pharmacy shall not be eligible to participate in the Participating Pharmacy Network effective January 1, 2006.

4. A Pharmacy shall not assign the PPA without prior written consent from CalOptima and the PBM. The Pharmacy to which the PPA is assigned shall meet all credentialing standards and the terms and conditions of the PPA as set forth in this policy.

III. PROCEDURE

A. Delegation

1. Except as otherwise indicated herein, the Pharmacy credentialing process shall be delegated to a PBM according to a written agreement.

2. CalOptima shall oversee this delegated function and may reclaim the right to carry out the function, but shall not direct the daily operations of the function. CalOptima shall ensure, through oversight and monitoring of the data collection process and review of actual data on a sampling basis, that the function is conducted pursuant to the standards set forth herein. The PBM shall use the credentialing data it collects in connection with this policy solely for credentialing purposes and directory listings.

B. Credentialing Standards

1. All Participating Pharmacies in the Participating Pharmacy Network shall meet the credentialing standards set forth herein. ~~The licensed dispensing areas of community clinics shall meet the credentialing standards, except as otherwise noted below.~~

2. Each Applicant Pharmacy and Participating Pharmacy shall meet the following credentialing standards both initially and on an ongoing basis:

a. Completion of the PBM Pharmacy Provider Credentialing Sheet: Each Applicant Pharmacy and Participating Pharmacy shall complete the PBM Provider Credentialing Sheet and submit the PBM Provider Credentialing Sheet to the PBM within the timeframes specified in this policy.

b. Board of Pharmacy ~~Permit/Board of Pharmacy Clinic~~ Permit: Each Applicant Pharmacy and Participating Pharmacy shall have an applicable Board of Pharmacy permit and shall post the permit in public view on the licensed premises in accordance with State Board of Pharmacy regulations.

c. Drug Enforcement Agency (DEA) Certificate: If the Applicant Pharmacy or Participating Pharmacy stocks or dispenses controlled substances, it shall have a current DEA certificate for the handling of controlled substances and shall post the certificate on the licensed premises in accordance with state and federal law.

d. Seller's Permit: Each Applicant Pharmacy and Participating Pharmacy shall have a current seller's permit and shall post the permit in public view on the licensed premises. If the permit has not been renewed within thirty (30) calendar days past its expiration date, the Applicant Pharmacy and Participating Pharmacy shall provide to the PBM a written explanation for the delay in renewal.

e. Pharmacist License and Professional Educational Degrees: Each Pharmacist employed at a Participating Pharmacy shall have a current Pharmacist's license issued by the state in which the Pharmacist practices. Each Pharmacist shall keep the original license on his or her person at all times while on duty at the Pharmacy. Each Pharmacist shall supply copies of any supporting documentation, including the current license and professional educational degrees within ten (10) calendar days after receipt of a written request.

~~f. Registered Nurse License and Professional Educational Degrees: Each registered nurse employed at a community clinic shall have a current license issued by the state in which the registered nurse practices, and shall post the license within the licensed area in accordance with State Board of Nursing regulations. Each registered nurse shall keep the original license on his or her person at all times while on duty at the community clinic. Each registered nurse shall supply copies of any supporting documentation, including the current license and professional educational degrees within ten (10) calendar days after receipt of a written request.~~

~~g.~~f. Pharmacy Technician Registration and Professional Educational Degree/Certificate: Each Pharmacy Technician employed at an Applicant Pharmacy, or Participating Pharmacy, shall have a current Pharmacy Technician registration issued by the state in which the Pharmacy Technician practices, and shall post the registration within the licensed premises in accordance with State Board of Pharmacy regulations. Each Pharmacy Technician shall keep the original registration certificate on his or her person at all times while on duty in the Pharmacy. Each Pharmacy Technician shall supply copies of any documentation supporting his or her registration, including the registration and professional educational degree/certificate within ten (10) calendar days after receipt of a written request.

~~h.~~g. Liability Insurance: Each Applicant Pharmacy and Participating Pharmacy shall purchase adequate professional liability insurance as evidenced by a current and valid insurance certificate listing the name of the insuring entity, the name of the insured Pharmacy, the amounts carried, and the expiration date of the policy. The Pharmacy shall either keep the

original insurance certificate or a copy thereof on the licensed premises or make a copy of the certificate available within ten (10) calendar days after receipt of a written request.

~~i.~~h. Medi-Cal/Medicaid Eligibility: Each Applicant Pharmacy and Participating Pharmacy shall maintain eligibility to provide Pharmaceutical Services under the Medicaid program in the state in which it has licensed premises at all times during the term of the PPA and shall maintain written proof of such eligibility on the licensed premises, or supply a copy of the written proof of its Medi-Cal/Medicaid eligibility within ten (10) calendar days after receipt of a written request. CalOptima shall not accept a previous owner's Medi-Cal/Medicaid provider number for a Pharmacy to which a PPA is Assigned.

~~j.~~i. Pharmacist-in-Charge (PIC): Each Applicant Pharmacy and Participating Pharmacy shall provide the PBM with the name and license number of the designated PIC as required by Title 16, California Code of Regulations, Section 1709.1. ~~Each Applicant Pharmacy and Participating Pharmacy that is a community clinic shall provide the name of the clinic's professional director who shall be responsible for the legal compliance of the clinic's dispensing operation.~~

~~k.~~j. Names and License/Registration Numbers of Pharmacists~~,~~ and Pharmacy Technicians~~, and Registered Nurses~~: Each Applicant Pharmacy and Participating Pharmacy shall provide the PBM with the names and license or registration numbers of each of the Pharmacists~~,~~ and Pharmacy Technicians~~, and registered nurses~~ employed at the Pharmacy.

~~l.~~k. California Board of Pharmacy Self-Assessment Tool: If the Applicant Pharmacy, or Participating Pharmacy, is licensed in California, it shall have on its licensed premises a current and complete California Board of Pharmacy Self-Assessment form in accordance with the requirements specified in Title 16, California Code of Regulations, Section 1715. If the Applicant Pharmacy, or Participating Pharmacy, is licensed outside of California, it shall be subject to the regulations of the state in which it is located. ~~Community clinics are exempt from this requirement.~~

~~m.~~l. Ownership: Each Applicant Pharmacy and Participating Pharmacy shall provide to the PBM the name, business address, and telephone number of its owner(s). Each Applicant Pharmacy and Participating Pharmacy shall disclose all other Pharmacies by National Council on Prescription Drug Programs (NCPDP), Name, and Address in which an owner has ownership, or a controlled interest of at least five percent (5%).

~~n.~~m. Fax Machine: Each Applicant Pharmacy and Participating Pharmacy shall maintain in good operating condition on its licensed premises a fax machine to be used to transmit CalOptima Pharmacy Prior Authorization Requests and other documents as may be required to the PBM in order to meet the timeframes of the prior authorization process. The fax machine must operate in accordance with International Telecommunications Union (ITU) Group 3 (G3) protocol, and must support V.21, V.27TER, and V.17 modem standards.

~~o.~~n. Computer System, Claims Submission, and Drug Utilization Review (DUR): Each Applicant Pharmacy and Participating Pharmacy shall maintain in good operating condition on its licensed premises a computer system that utilizes Pharmacy Prescription processing software for the processing of online, real time Prescription claims. The Prescription processing software shall be certified by its manufacturer, or distributor, as compatible with the most current version of the NCPDP standards for electronic Pharmacy claims. The computer system shall include printing equipment used to generate labels which are affixed to the container of each Prescription dispensed to Members, and which comply with all

regulatory requirements for Prescription labeling. Each Pharmacy's computer system must be capable of receiving and allowing the operator to immediately respond to electronic Drug Utilization Review (DUR) and other messages sent by the PBM to the Pharmacy. ~~Community clinics are exempt from this subparagraph "o."~~

~~p.~~o. Medicare Provider: Each Applicant Pharmacy and Participating Pharmacy shall be a registered Medicare provider in active standing.

~~q.~~p. An Applicant Pharmacy and Participating Pharmacy shall meet additional requirements as set forth in the PPA including, but not limited to, fraud assessment requirements.

C. Adverse Actions

1. If an Applicant Pharmacy, its owner, PIC, Pharmacists, or Pharmacy Technicians have, at any time within five (5) years prior to the Applicant Pharmacy's application, been subject to adverse action including, but not limited to, written field admonishment, citations, judgments, stipulations, ineligibility for, or suspension from, any Medicaid or any Medicare program by CalOptima, or any ~~other~~ regulatory or law enforcement agency, the Applicant Pharmacy shall disclose to the PBM, in writing, the material details and conditions associated with any such adverse action upon submission of the PBM Pharmacy Provider Credentialing Sheet.

2. If a Participating Pharmacy, its owner, PIC, Pharmacists, or Pharmacy Technicians at any time during the term of the PPA become subject to adverse action including, but not limited to, written field admonishment, citations, judgments, stipulations, ineligibility for, or suspension from, any Medicaid, or any Medicare, program by CalOptima, or any ~~other~~ regulatory or law enforcement agency, the Participating Pharmacy shall, within ten (10) calendar days after such adverse action, disclose to the PBM, in writing, the material details and conditions associated with any such adverse action.

3. Failure to disclose adverse actions as required by Section III.C.1. and III.C.2. of this policy may result in denial of participation for an Applicant Pharmacy or termination of the PPA for a Participating Pharmacy.

4. CalOptima may require a Pharmacy to file appropriate affidavits and other evidence of the Pharmacy's capacity to meet the standards set forth in this policy and to perform the requirements of the PPA, as well as the express written consent of its authorized representative, before allowing an Applicant Pharmacy to participate in the Participating Pharmacy Network.

D. Initial Credentialing of Applicant Pharmacy

1. For those Applicant Pharmacies that apply to become part of the Participating Pharmacy Network, the PBM shall initially review each Applicant Pharmacy's Pharmacy Provider Credentialing Sheet within thirty (30) calendar days after submission.

   a. If necessary, the PBM shall request in writing any additional information from the Applicant Pharmacy at least five (5) calendar days prior to the expiration of the initial thirty (30) day review period.

   b. The Applicant Pharmacy shall respond, in writing, within fourteen (14) calendar days after the request. The Applicant Pharmacy's failure to respond to such requests may result in denial of the Applicant Pharmacy's request to participate in the Participating Pharmacy Network.

2. The PBM shall determine if the Applicant Pharmacy meets the credentialing standards as set forth in Section III.B. of this policy and issue a final decision, in writing, within sixty (60) calendar days after the receipt of the Applicant Pharmacy's Provider Credentialing Sheet. The PBM shall:

   a. Admit the Applicant Pharmacy to the Participating Pharmacy Network without stipulations upon receiving a signed PPA from the Pharmacy;

   b. Admit the Applicant Pharmacy to the Participating Pharmacy Network with stipulations upon receiving a signed PPA from the Pharmacy; or

   c. Deny the Applicant Pharmacy's request to participate in the Participating Pharmacy Network.

3. The PBM may require the Applicant Pharmacy to file a written attestation of compliance with any stipulations or other specified terms and conditions before granting the Pharmacy's request for admission to the Participating Pharmacy Network and issuing a PPA including, but not limited to, submitting to an onsite Audit to be performed by CalOptima's Pharmacy Auditor.

E. Failure to Meet and Maintain Credentialing Standards

1. If the PBM determines that an Applicant Pharmacy does not meet all of the credentialing standards set forth herein, it shall deny the Pharmacy's request to be admitted to the Participating Pharmacy Network. The Pharmacy may reapply for network status after correction of the credentialing deficiency(ies).

2. If the PBM determines that a Participating Pharmacy fails to meet one (1) or more of the credentialing standards set forth herein at any point after entering into a PPA, it shall notify the Participating Pharmacy of its deficiency, in writing, and identify any required corrective action, if any, and the time frame within which the Pharmacy must take such corrective action. Failure of the Pharmacy to make the corrections within the specified time frame may result in further action as authorized by the PPA.

D. PBM Responsibilities

1. Network Compliance with Credentialing Standards

   a. The PBM shall collect credentialing data from each Applicant Pharmacy before the Pharmacy is offered a PPA in order to ensure that the Pharmacy meets CalOptima's credentialing standards set forth in Section III.B. of this policy. The PBM shall continue to collect credentialing data from each Participating Pharmacy in order to recredential each Participating Pharmacy every twenty-four (24) months.

   b. The PBM shall maintain the credentialing data of each Participating Pharmacy in an electronic database for retrieval and updating in accordance with this policy.

   c. In addition to taking any additional action allowed or required by the PPA, the PBM shall send to each Participating Pharmacy a report of any failure to meet a credentialing standard, which shall include a description of the required corrective action(s) and a form upon which the Participating Pharmacy may verify its compliance with such corrective actions, and

provide any required information or documentation. The PBM shall record the corrective action in the database.

d. The PBM shall report to CalOptima a Participating Pharmacy's failure to meet a credentialing standard within fifteen (15) calendar days after notice of the failure.

2. Reporting to CalOptima

a. Applicant Pharmacies: The PBM shall provide to CalOptima on a monthly basis a cumulative report of all Applicant Pharmacies. The report shall reflect each Pharmacy's compliance, or noncompliance, with each of CalOptima's credentialing standards, and shall include the final determination for each Applicant Pharmacy.

b. Participating Pharmacy Network: The PBM shall provide a written report to CalOptima on a monthly basis reporting all additions, changes, and deletions to the Participating Pharmacy Network and a list of all Participating Pharmacies, including each Pharmacy's location by county.

c. Credentialing Activities: The PBM shall provide written reports to CalOptima showing its credentialing activities including a summary of the determinations made for each Applicant Pharmacy.

E. Pharmacy Auditor Responsibilities

1. CalOptima, or its Pharmacy Auditor, may perform Audits (onsite reviews) to monitor and verify the Participating Pharmacy's compliance with the standards set forth in this policy.

2. Such Audits shall be performed in accordance with the terms and conditions of CalOptima Policy GG.1408: Pharmacy Audits and Reviews.

F. CalOptima Responsibilities

1. Oversight of PBM: CalOptima shall oversee the PBM's data collection processes, tools, and communications to Pharmacies regarding the credentialing and access standards and procedures set forth herein.

2. Participating Pharmacy Network: CalOptima shall periodically review its Participating Pharmacy Network to ensure that the standards set forth in this policy are appropriate to ensure adequate Member access to Pharmaceutical Services.

G. Grievance

1. A Participating Pharmacy that is dissatisfied with any decision made pursuant to this policy may file a grievance within fifteen (15) calendar days after the date of the decision, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

2. If a timely request for a grievance is filed, any decision made by CalOptima shall be stayed during the grievance process, unless CalOptima determines that to stay the decision is not in the best interests of its Members.

3. If a timely grievance is not requested, the decision shall be effective upon the expiration of the period during which a grievance may be requested.

IV. ATTACHMENT(S)

A. PBM Pharmacy Provider Credentialing Sheet

V. REFERENCE(S)

A. California Evidence Code, §1157
B. California Business and Professions Code, §4040
C. California Welfare and Institutions Code, §14087.58(b)
D. Title 16, California Code of Regulations (C.C.R.), ~~§§§§~~1709, 1709.1 and 1715
E. Title 22, California Code of Regulations (C.C.R.), §51180
F. Title 42, Code of Federal Regulations (C.F.R.), §423.120(a)
G. Social Security Act, ~~§§§§~~1124, 1819(a), and 1860D-4(b)(1)(C)
H. CalOptima Pharmacy Benefit Manager Agreement
I. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
J. CalOptima Policy HH.1101: CalOptima Provider Complaint
K. CalOptima Policy MA.9006: Provider Complaint Process
L. National Council on Prescription Drug Programs (NCPDP) Telecommunication Standards (available from NCPDP)
M. Participating Pharmacy Agreement
N. Pharmacy Law with Rules and Regulations, California Edition, California Board of Pharmacy, Law Tech Publishing Co., Ltd.
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-005: Network Certification Requirements

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
01/10/06	Regular Meeting of the CalOptima Board of Directors
11/01/05	Regular Meeting of the CalOptima Board of Directors
02/01/05	Regular Meeting of the CalOptima Board of Directors
08/10/04	Regular Meeting of the CalOptima Board of Directors
01/11/00	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
~~Effective~~	~~03/01/1999~~	~~GG.1406~~	~~Pharmacy Network: Credentialing and Access~~	~~Medi-Cal~~
~~Revised~~	~~02/01/2015~~	~~MA.1406~~	~~Pharmacy Network: Credentialing and Access~~	~~Medi-Cal~~
Effective	11/01/1999	GG.1406	Pharmacy Network: Credentialing and Access	Medi-Cal
Revised	08/01/2000	GG.1406	Pharmacy Network: Credentialing and Access	Medi-Cal

Action	Date	Policy	Policy Title	Program(s)
Revised	02/01/2005	GG.1406	Pharmacy Network: Credentialing and Access	Medi-Cal
Revised	01/10/2006	GG.1406	Pharmacy Network: Credentialing and Access	Medi-Cal
Revised	02/01/2015	MA.1406	Pharmacy Network: Credentialing and Access	OneCare OneCare Connect PACE
Revised	01/01/2016	GG.1406Δ	Pharmacy Network: Credentialing and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	02/01/2017	GG.1406Δ	Pharmacy Network: Credentialing and Access	Medi-Cal OneCare OneCare Connect PACE
Revised	10/01/2018	GG.1406Δ	Pharmacy Network: Credentialing and Access	Medi-Cal OneCare OneCare Connect PACE
Revised		GG.1406Δ	Pharmacy Network: Credentialing and Access	Medi-Cal OneCare OneCare Connect PACE

IX. GLOSSARY

Term	Definition
Audit	Any review or audit of a Pharmacy performed by CalOptima, CalOptima's authorized representative, or by any regulatory or law enforcement agency, except, however, any review or audit of a Pharmacy conducted by the PBM or its designee.
Applicant Pharmacy	A Pharmacy that applies to become part of the Participating Pharmacy Network by submitting a request to the PBM.
Assignment (Pharmacy)	Any of the following: 1. Change of more than twenty-five percent (25%) of the ownership or equity interest in a Pharmacy (whether in a single transaction or in a series of transactions); 2. The merger, reorganization, or consolidation of a Pharmacy with another entity with respect to which the Pharmacy is not the surviving entity; or 3. A change in the management of a Pharmacy from management by persons appointed or otherwise selected by the governing body of the Pharmacy (e.g., the Board of Directors) to a third-party manager or management company.
Chain Pharmacy	Multiple licensed retail Pharmacies operated under a single business name and logo in a standardized manner, which follow a uniform set of policies and procedures covering all aspects of their operation, and which are organized under a single ownership and management structure (definition excludes franchises).
Closed Pharmacy	A licensed Pharmacy that is not open to the general public, but either provides Pharmaceutical Services to select patient populations that reside in one (1) or more state-licensed facilities, or to patients residing in their homes, excluding Mail Order Pharmacies and Internet Pharmacies.
Health Network	A Physician Hospital Consortium (PHC), pPhysician ~~Medical Group~~ group (~~PMG~~) 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.
Independent Pharmacy	One (1) or more licensed retail Pharmacies operated under a single business name or multiple business names, or which may be linked under a unique marketing logo or name, but which operate independently of each other as shown by an absence of a uniform set of operating policies and procedures covering all aspects of their operation, and which may or may not be organized under a single ownership and management structure, including franchises
Institution	A facility that meets Medicare's definition of a skilled nursing facility, such as a nursing home and any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Social Security Act. Institution does not include assisted or adult living facilities, or residential homes.
Internet Pharmacy	A licensed Pharmacy that accepts Prescription requests and conducts the majority of its Prescription business through an Internet web site and which distributes the Prescription medications and supplies for consumer use

Term	Definition
	through the United States (U.S.) mail or by use of other common carrier services.
Long Term Care Pharmacy	A licensed Pharmacy that services Members residing in Institutions and meets the following performance and service criteria developed by the Centers for Medicare & Medicaid Services (CMS): 1. Comprehensive inventory and inventory capacity; 2. Pharmacy operations and Prescription orders; 3. Special packaging; 4. Intravenous (IV) medications; 5. Compounding or alternative forms of drug composition; 6. Pharmacist on-call service; 7. Delivery service; 8. Emergency boxes; 9. Emergency log books; and 10. Miscellaneous reports, forms, and Prescription ordering supplies.
Mail Order Pharmacy	A licensed Pharmacy that accepts Prescription requests by U.S. mail or electronic facsimile and that conducts the majority of its Prescription business by U.S. mail, and that distributes the majority of its dispensed Prescription medications for consumer use by U.S. mail or by use of other common carrier services.
Member	An enrollee-beneficiary of a CalOptima program.
Participating Pharmacy	Any Pharmacy that is credentialed by and contracted with the PBM to provide Pharmaceutical Services to Members.
Participating Pharmacy Agreement (PPA)	The contract between the PBM and a Participating Pharmacy that provides Pharmaceutical Services to Members.
Participating Pharmacy Network	The Pharmacies that are authorized by the PBM to provide Pharmaceutical Services to Members, as set forth in CalOptima's list of Participating Pharmacies.
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.
Pharmacist	A person to whom the State Board of Pharmacy has issued a license, authorizing the person to practice pharmacy
Pharmacist-In-Charge (PIC)	The licensed Pharmacist designated by each Pharmacy in accordance with Title 16, California Code of Regulations, Section 1709.1, who is legally responsible for that Pharmacy's compliance with all state and federal laws and regulations pertaining to the practice of pharmacy.
Pharmacy	An area, place, or premises licensed by the State Board of Pharmacy, in which the profession of pharmacy is practiced and where Prescriptions are compounded and dispensed, and for the purposes of this policy, the licensed dispensing area of a community clinic.
Pharmacy Auditor	An entity contracted with CalOptima to perform Audits of its Participating Pharmacies, or CalOptima staff designated to perform such Audits.

Term	Definition
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.
Pharmacy Benefit Manager (PBM) Services Agreement	The written agreement between a PBM and CalOptima regarding the delivery and maintenance of the Participating Pharmacy Network.
Pharmacy Technician	A person who assists a Pharmacist in the performance of Pharmacy-related duties, to whom the State Board of Pharmacy has issued a certificate of registration to act as a Pharmacy Technician.
Prescription	An oral, written, or electronic transmission order that meets the requirements of the California Business and Professions Code, Chapter 9, Division 2, Article 2, Section 4040.
Purchase Records	All of Participating Pharmacy's purchase invoices, periodic statements, and credit or return memos from all sources, and documentation of the Participating Pharmacy's payments for all drug or medical supply acquisitions, including business bank statements, copies of checks, and any other documents required by the PBM or CalOptima.
Records	All physical and electronic records of drug and medical devise acquisition from and disposition to all persons and entities including, but not limited to: drug wholesalers, drug manufacturers and distributors, other Pharmacies and Members, and any other document related to the terms of the PPA. Such Records include, but are not limited to: license and credentialing records, claims transaction records, Purchase Records, Prescriptions (including all physical and electronic notations related to every Prescription), all Member signature logs, records of payments for drug and device acquisitions, and remittance advice records from the PBM.
Retail Pharmacy	A Pharmacy open for business to the general public, excluding Mail Order Pharmacies and Internet Pharmacies.

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Policy #:	GG.1406Δ
Title:	**Pharmacy Network: Credentialing and Access**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	03/01/99
Last Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy establishes Pharmacy credentialing and access standards and to set forth a procedure by which the Pharmacy Benefit Manager (PBM) shall determine if a Pharmacy and its professional and technical staff meet credentialing standards and if Members have appropriate geographic access to the Participating Pharmacy Network.

II. POLICY

A. Credentialing Standards

1. CalOptima shall establish credentialing standards, as set forth herein, and review those standards periodically.

2. CalOptima may delegate the process for credentialing and recredentialing each Pharmacy and its professional and technical staff to a Pharmacy Benefit Manager (PBM) through a written agreement.

3. Each Participating Pharmacy and its professional and technical staff shall meet CalOptima's credentialing standards and shall be credentialed prior to entering into a Participating Pharmacy Agreement (PPA) and recredentialed every two (2) years thereafter.

4. All peer review and quality assessment reports and Records produced and obtained pursuant to this Policy shall be governed by California Welfare and Institutions Code, Section 14087.58(b), and California Evidence Code, Section 1157.

5. CalOptima shall provide oversight of the credentialing and recredentialing process, including conducting an annual Audit of the PBM's credentialing process to ensure compliance with the standards set forth herein.

B. Access Standards

1. CalOptima shall ensure that each Member has access to Pharmaceutical Services as follows:

   a. At least ninety percent (90%) of Members, on average, in urban areas live within two (2) miles of a Participating Pharmacy;

b. At least ninety percent (90%) of Members, on average, in suburban areas live within five (5) miles of a Participating Pharmacy; and

c. At least seventy percent (70%) of Members, on average, in rural areas live within fifteen (15) miles of a Participating Pharmacy.

2. Members shall have access to network pharmacies within ten (10) miles or thirty (30) minutes of their residence.

3. CalOptima may delegate the responsibility for determining whether or not access standards are met to the PBM.

C. Participation in Participating Pharmacy Network

1. Before providing Pharmaceutical Services to a Member, a Pharmacy that meets the terms and conditions of the PPA and credentialing standards shall sign the most current version of the PPA.

2. A signed PPA with a Chain Pharmacy shall be applicable to the individually licensed locations of that Chain Pharmacy that meet the credentialing standards set forth herein.

3. If a Pharmacy had been eligible, but chose not, to participate in the Participating Pharmacy Network between January 1, 2005, and December 31, 2005, such Pharmacy shall not be eligible to participate in the Participating Pharmacy Network effective January 1, 2006.

4. A Pharmacy shall not assign the PPA without prior written consent from CalOptima and the PBM. The Pharmacy to which the PPA is assigned shall meet all credentialing standards and the terms and conditions of the PPA as set forth in this policy.

III. PROCEDURE

A. Delegation

1. Except as otherwise indicated herein, the Pharmacy credentialing process shall be delegated to a PBM according to a written agreement.

2. CalOptima shall oversee this delegated function and may reclaim the right to carry out the function, but shall not direct the daily operations of the function. CalOptima shall ensure, through oversight and monitoring of the data collection process and review of actual data on a sampling basis, that the function is conducted pursuant to the standards set forth herein. The PBM shall use the credentialing data it collects in connection with this policy solely for credentialing purposes and directory listings.

B. Credentialing Standards

1. All Participating Pharmacies in the Participating Pharmacy Network shall meet the credentialing standards set forth herein.

2. Each Applicant Pharmacy and Participating Pharmacy shall meet the following credentialing standards both initially and on an ongoing basis:

a. Completion of the PBM Pharmacy Provider Credentialing Sheet: Each Applicant Pharmacy and Participating Pharmacy shall complete the PBM Provider Credentialing Sheet and submit the PBM Provider Credentialing Sheet to the PBM within the timeframes specified in this policy.

b. Board of Pharmacy Permit: Each Applicant Pharmacy and Participating Pharmacy shall have an applicable Board of Pharmacy permit and shall post the permit in public view on the licensed premises in accordance with State Board of Pharmacy regulations.

c. Drug Enforcement Agency (DEA) Certificate: If the Applicant Pharmacy or Participating Pharmacy stocks or dispenses controlled substances, it shall have a current DEA certificate for the handling of controlled substances and shall post the certificate on the licensed premises in accordance with state and federal law.

d. Seller's Permit: Each Applicant Pharmacy and Participating Pharmacy shall have a current seller's permit and shall post the permit in public view on the licensed premises. If the permit has not been renewed within thirty (30) calendar days past its expiration date, the Applicant Pharmacy and Participating Pharmacy shall provide to the PBM a written explanation for the delay in renewal.

e. Pharmacist License and Professional Educational Degrees: Each Pharmacist employed at a Participating Pharmacy shall have a current Pharmacist's license issued by the state in which the Pharmacist practices. Each Pharmacist shall keep the original license on his or her person at all times while on duty at the Pharmacy. Each Pharmacist shall supply copies of any supporting documentation, including the current license and professional educational degrees within ten (10) calendar days after receipt of a written request.

f. Pharmacy Technician Registration and Professional Educational Degree/Certificate: Each Pharmacy Technician employed at an Applicant Pharmacy, or Participating Pharmacy, shall have a current Pharmacy Technician registration issued by the state in which the Pharmacy Technician practices, and shall post the registration within the licensed premises in accordance with State Board of Pharmacy regulations. Each Pharmacy Technician shall keep the original registration certificate on his or her person at all times while on duty in the Pharmacy. Each Pharmacy Technician shall supply copies of any documentation supporting his or her registration, including the registration and professional educational degree/certificate within ten (10) calendar days after receipt of a written request.

g. Liability Insurance: Each Applicant Pharmacy and Participating Pharmacy shall purchase adequate professional liability insurance as evidenced by a current and valid insurance certificate listing the name of the insuring entity, the name of the insured Pharmacy, the amounts carried, and the expiration date of the policy. The Pharmacy shall either keep the original insurance certificate or a copy thereof on the licensed premises or make a copy of the certificate available within ten (10) calendar days after receipt of a written request.

h. Medi-Cal/Medicaid Eligibility: Each Applicant Pharmacy and Participating Pharmacy shall maintain eligibility to provide Pharmaceutical Services under the Medicaid program in the state in which it has licensed premises at all times during the term of the PPA and shall maintain written proof of such eligibility on the licensed premises, or supply a copy of the written proof of its Medi-Cal/Medicaid eligibility within ten (10) calendar days after receipt of a written request. CalOptima shall not accept a previous owner's Medi-Cal/Medicaid provider number for a Pharmacy to which a PPA is Assigned.

i. Pharmacist-in-Charge (PIC): Each Applicant Pharmacy and Participating Pharmacy shall provide the PBM with the name and license number of the designated PIC as required by Title 16, California Code of Regulations, Section 1709.1.

j. Names and License/Registration Numbers of Pharmacists and Pharmacy Technicians: Each Applicant Pharmacy and Participating Pharmacy shall provide the PBM with the names and license or registration numbers of each of the Pharmacists and Pharmacy Technicians employed at the Pharmacy.

k. California Board of Pharmacy Self-Assessment Tool: If the Applicant Pharmacy, or Participating Pharmacy, is licensed in California, it shall have on its licensed premises a current and complete California Board of Pharmacy Self-Assessment form in accordance with the requirements specified in Title 16, California Code of Regulations, Section 1715. If the Applicant Pharmacy, or Participating Pharmacy, is licensed outside of California, it shall be subject to the regulations of the state in which it is located.

l. Ownership: Each Applicant Pharmacy and Participating Pharmacy shall provide to the PBM the name, business address, and telephone number of its owner(s). Each Applicant Pharmacy and Participating Pharmacy shall disclose all other Pharmacies by National Council on Prescription Drug Programs (NCPDP), Name, and Address in which an owner has ownership, or a controlled interest of at least five percent (5%).

m. Fax Machine: Each Applicant Pharmacy and Participating Pharmacy shall maintain in good operating condition on its licensed premises a fax machine to be used to transmit CalOptima Pharmacy Prior Authorization Requests and other documents as may be required to the PBM in order to meet the timeframes of the prior authorization process. The fax machine must operate in accordance with International Telecommunications Union (ITU) Group 3 (G3) protocol, and must support V.21, V.27TER, and V.17 modem standards.

n. Computer System, Claims Submission, and Drug Utilization Review (DUR): Each Applicant Pharmacy and Participating Pharmacy shall maintain in good operating condition on its licensed premises a computer system that utilizes Pharmacy Prescription processing software for the processing of online, real time Prescription claims. The Prescription processing software shall be certified by its manufacturer, or distributor, as compatible with the most current version of the NCPDP standards for electronic Pharmacy claims. The computer system shall include printing equipment used to generate labels which are affixed to the container of each Prescription dispensed to Members, and which comply with all regulatory requirements for Prescription labeling. Each Pharmacy's computer system must be capable of receiving and allowing the operator to immediately respond to electronic Drug Utilization Review (DUR) and other messages sent by the PBM to the Pharmacy.

o. Medicare Provider: Each Applicant Pharmacy and Participating Pharmacy shall be a registered Medicare provider in active standing.

p. An Applicant Pharmacy and Participating Pharmacy shall meet additional requirements as set forth in the PPA including, but not limited to, fraud assessment requirements.

C. Adverse Actions

1. If an Applicant Pharmacy, its owner, PIC, Pharmacists, or Pharmacy Technicians have, at any time within five (5) years prior to the Applicant Pharmacy's application, been subject to adverse action including, but not limited to, written field admonishment, citations, judgments,

stipulations, ineligibility for, or suspension from, any Medicaid or any Medicare program by CalOptima, or any regulatory or law enforcement agency, the Applicant Pharmacy shall disclose to the PBM, in writing, the material details and conditions associated with any such adverse action upon submission of the PBM Pharmacy Provider Credentialing Sheet.

2. If a Participating Pharmacy, its owner, PIC, Pharmacists, or Pharmacy Technicians at any time during the term of the PPA become subject to adverse action including, but not limited to, written field admonishment, citations, judgments, stipulations, ineligibility for, or suspension from, any Medicaid, or any Medicare, program by CalOptima, or any regulatory or law enforcement agency, the Participating Pharmacy shall, within ten (10) calendar days after such adverse action, disclose to the PBM, in writing, the material details and conditions associated with any such adverse action.

3. Failure to disclose adverse actions as required by Section III.C.1. and III.C.2. of this policy may result in denial of participation for an Applicant Pharmacy or termination of the PPA for a Participating Pharmacy.

4. CalOptima may require a Pharmacy to file appropriate affidavits and other evidence of the Pharmacy's capacity to meet the standards set forth in this policy and to perform the requirements of the PPA, as well as the express written consent of its authorized representative, before allowing an Applicant Pharmacy to participate in the Participating Pharmacy Network.

D. Initial Credentialing of Applicant Pharmacy

1. For those Applicant Pharmacies that apply to become part of the Participating Pharmacy Network, the PBM shall initially review each Applicant Pharmacy's Pharmacy Provider Credentialing Sheet within thirty (30) calendar days after submission.

   a. If necessary, the PBM shall request in writing any additional information from the Applicant Pharmacy at least five (5) calendar days prior to the expiration of the initial thirty (30) day review period.

   b. The Applicant Pharmacy shall respond, in writing, within fourteen (14) calendar days after the request. The Applicant Pharmacy's failure to respond to such requests may result in denial of the Applicant Pharmacy's request to participate in the Participating Pharmacy Network.

2. The PBM shall determine if the Applicant Pharmacy meets the credentialing standards as set forth in Section III.B. of this policy and issue a final decision, in writing, within sixty (60) calendar days after the receipt of the Applicant Pharmacy's Provider Credentialing Sheet. The PBM shall:

   a. Admit the Applicant Pharmacy to the Participating Pharmacy Network without stipulations upon receiving a signed PPA from the Pharmacy;

   b. Admit the Applicant Pharmacy to the Participating Pharmacy Network with stipulations upon receiving a signed PPA from the Pharmacy; or

   c. Deny the Applicant Pharmacy's request to participate in the Participating Pharmacy Network.

3. The PBM may require the Applicant Pharmacy to file a written attestation of compliance with any stipulations or other specified terms and conditions before granting the Pharmacy's request for admission to the Participating Pharmacy Network and issuing a PPA including, but not limited to, submitting to an onsite Audit to be performed by CalOptima's Pharmacy Auditor.

E. Failure to Meet and Maintain Credentialing Standards

1. If the PBM determines that an Applicant Pharmacy does not meet all of the credentialing standards set forth herein, it shall deny the Pharmacy's request to be admitted to the Participating Pharmacy Network. The Pharmacy may reapply for network status after correction of the credentialing deficiency(ies).

2. If the PBM determines that a Participating Pharmacy fails to meet one (1) or more of the credentialing standards set forth herein at any point after entering into a PPA, it shall notify the Participating Pharmacy of its deficiency, in writing, and identify any required corrective action, if any, and the time frame within which the Pharmacy must take such corrective action. Failure of the Pharmacy to make the corrections within the specified time frame may result in further action as authorized by the PPA.

D. PBM Responsibilities

1. Network Compliance with Credentialing Standards

a. The PBM shall collect credentialing data from each Applicant Pharmacy before the Pharmacy is offered a PPA in order to ensure that the Pharmacy meets CalOptima's credentialing standards set forth in Section III.B. of this policy. The PBM shall continue to collect credentialing data from each Participating Pharmacy in order to recredential each Participating Pharmacy every twenty-four (24) months.

b. The PBM shall maintain the credentialing data of each Participating Pharmacy in an electronic database for retrieval and updating in accordance with this policy.

c. In addition to taking any additional action allowed or required by the PPA, the PBM shall send to each Participating Pharmacy a report of any failure to meet a credentialing standard, which shall include a description of the required corrective action(s) and a form upon which the Participating Pharmacy may verify its compliance with such corrective actions, and provide any required information or documentation. The PBM shall record the corrective action in the database.

d. The PBM shall report to CalOptima a Participating Pharmacy's failure to meet a credentialing standard within fifteen (15) calendar days after notice of the failure.

2. Reporting to CalOptima

a. Applicant Pharmacies: The PBM shall provide to CalOptima on a monthly basis a cumulative report of all Applicant Pharmacies. The report shall reflect each Pharmacy's compliance, or noncompliance, with each of CalOptima's credentialing standards, and shall include the final determination for each Applicant Pharmacy.

b. Participating Pharmacy Network: The PBM shall provide a written report to CalOptima on a monthly basis reporting all additions, changes, and deletions to the Participating

Pharmacy Network and a list of all Participating Pharmacies, including each Pharmacy's location by county.

c. Credentialing Activities: The PBM shall provide written reports to CalOptima showing its credentialing activities including a summary of the determinations made for each Applicant Pharmacy.

E. Pharmacy Auditor Responsibilities

1. CalOptima, or its Pharmacy Auditor, may perform Audits (onsite reviews) to monitor and verify the Participating Pharmacy's compliance with the standards set forth in this policy.

2. Such Audits shall be performed in accordance with the terms and conditions of CalOptima Policy GG.1408: Pharmacy Audits and Reviews.

F. CalOptima Responsibilities

1. Oversight of PBM: CalOptima shall oversee the PBM's data collection processes, tools, and communications to Pharmacies regarding the credentialing and access standards and procedures set forth herein.

2. Participating Pharmacy Network: CalOptima shall periodically review its Participating Pharmacy Network to ensure that the standards set forth in this policy are appropriate to ensure adequate Member access to Pharmaceutical Services.

G. Grievance

1. A Participating Pharmacy that is dissatisfied with any decision made pursuant to this policy may file a grievance within fifteen (15) calendar days after the date of the decision, in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint and MA.9006: Provider Complaint Process.

2. If a timely request for a grievance is filed, any decision made by CalOptima shall be stayed during the grievance process, unless CalOptima determines that to stay the decision is not in the best interests of its Members.

3. If a timely grievance is not requested, the decision shall be effective upon the expiration of the period during which a grievance may be requested.

IV. ATTACHMENT(S)

A. PBM Pharmacy Provider Credentialing Sheet

V. REFERENCE(S)

A. California Evidence Code, §1157
B. California Business and Professions Code, §4040
C. California Welfare and Institutions Code, §14087.58(b)
D. Title 16, California Code of Regulations (C.C.R.), §§1709, 1709.1 and 1715
E. Title 22, California Code of Regulations (C.C.R.), §51180
F. Title 42, Code of Federal Regulations (C.F.R.), §423.120(a)
G. Social Security Act, §§1124, 1819(a), and 1860D-4(b)(1)(C)

H. CalOptima Pharmacy Benefit Manager Agreement
I. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
J. CalOptima Policy HH.1101: CalOptima Provider Complaint
K. CalOptima Policy MA.9006: Provider Complaint Process
L. National Council on Prescription Drug Programs (NCPDP) Telecommunication Standards (available from NCPDP)
M. Participating Pharmacy Agreement
N. Pharmacy Law with Rules and Regulations, California Edition, California Board of Pharmacy, Law Tech Publishing Co., Ltd.
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-005: Network Certification Requirements

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTIONS

Date	Meeting
01/10/06	Regular Meeting of the CalOptima Board of Directors
11/01/05	Regular Meeting of the CalOptima Board of Directors
02/01/05	Regular Meeting of the CalOptima Board of Directors
08/10/04	Regular Meeting of the CalOptima Board of Directors
01/11/00	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/1999	GG.1406	Pharmacy Network: Credentialing and Access	Medi-Cal
Revised	08/01/2000	GG.1406	Pharmacy Network: Credentialing and Access	Medi-Cal
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Revised	10/01/2018	GG.1406Δ	Pharmacy Network: Credentialing and Access	Medi-Cal OneCare OneCare Connect PACE

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Institution	A facility that meets Medicare's definition of a skilled nursing facility, such as a nursing home and any medical institution or nursing facility for which payment is made for institutionalized individuals under Medicaid, as defined in section 1902(q)(1)(B) of the Social Security Act. Institution does not include assisted or adult living facilities, or residential homes.
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Pharmacy Auditor	An entity contracted with CalOptima to perform Audits of its Participating Pharmacies, or CalOptima staff designated to perform such Audits.

Term	Definition
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.
Pharmacy Benefit Manager (PBM) Services Agreement	The written agreement between a PBM and CalOptima regarding the delivery and maintenance of the Participating Pharmacy Network.
Pharmacy Technician	A person who assists a Pharmacist in the performance of Pharmacy-related duties, to whom the State Board of Pharmacy has issued a certificate of registration to act as a Pharmacy Technician.
Prescription	An oral, written, or electronic transmission order that meets the requirements of the California Business and Professions Code, Chapter 9, Division 2, Article 2, Section 4040.
Purchase Records	All of Participating Pharmacy's purchase invoices, periodic statements, and credit or return memos from all sources, and documentation of the Participating Pharmacy's payments for all drug or medical supply acquisitions, including business bank statements, copies of checks, and any other documents required by the PBM or CalOptima.
Records	All physical and electronic records of drug and medical devise acquisition from and disposition to all persons and entities including, but not limited to: drug wholesalers, drug manufacturers and distributors, other Pharmacies and Members, and any other document related to the terms of the PPA. Such Records include, but are not limited to: license and credentialing records, claims transaction records, Purchase Records, Prescriptions (including all physical and electronic notations related to every Prescription), all Member signature logs, records of payments for drug and device acquisitions, and remittance advice records from the PBM.
Retail Pharmacy	A Pharmacy open for business to the general public, excluding Mail Order Pharmacies and Internet Pharmacies.

1

MedImpact/CalOptima Pharmacy Provider Credentialing Form

PLEASE COMPLETE FOR EACH PHARMACY COVERED BY THE MedImpact/CalOptima PARTICIPATING PHARMACY AGREEMENT.

PLEASE PRINT LEGIBLY OR TYPE

Pharmacy Name*:* _____ NCPDP #_____

Federal Tax Identification number: _____ Pharmacy NPI: _____

Pharmacy Address: _____

City/State/Zip: _____ County: _____

Phone Number: _____ Fax Number: _____

Website Address: _____ e-mail Address_____

Software Vendor: _____ Vendor's phone number_____

PSAO Name: _____

This pharmacy is a: ☐ Corporation ☐ LLP ☐ Sole proprietorship ☐Other _____

Corporation Name (if applicable): _____

Mailing Address: _____

City/State/Zip: _____

Pay to Address: _____

City/State/Zip: _____

DEA #: _____ Expiration Date: _____

State Board of Pharmacy License #: _____ Expiration Date: _____

Medi-Cal #: _____ Medicare/PTAN#: _____

Pharmacy Type of Business (check all that apply):

☐ Home Infusion Pharmacy
☐ Community Chain Pharmacy
☐ Community Independent Pharmacy
☐ Hospital Based Pharmacy
☐ Long Term Care Pharmacy
☐ Board and Care Pharmacy
☐ Internet Pharmacy
☐ ICF Pharmacy
☐ Specialty Pharmacy
☐ Mail Order Pharmacy

Is Pharmacy eligible to purchase discounted drugs under the PHS Drug Pricing Program (340B) as an eligible covered entity? ☐ Yes ☐ No

Entity Name: _____ Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Does Pharmacy currently purchase medications under the PHS Drug Pricing Program (340B)? ☐ Yes ☐ No

Pharmacy Hours of Operation:

Monday- Friday: ____ a.m. to ____ p.m. Saturday: ____ a.m. to ____ p.m. Sunday: ____ a.m. to ____ p.m.

Open 24 hours? ☐ Yes ☐ No Open Holidays? ☐ Yes ☐ No

Does your pharmacy provide after-hours emergency prescription services? ☐ Yes ☐ No

Is this pharmacy a closed-door pharmacy? ☐ Yes ☐ No

Does this pharmacy have internet access? ☐ Yes ☐ No

Does your pharmacy electronically bill cross-over claims? ☐ Yes ☐ No

Does your pharmacy provide delivery services to the patient's home? ☐ Yes ☐ No

Are there any restrictions for delivery (e.g. fees, distance)? ☐ Free Home Delivery

☐ Mileage _____ ☐Fee_____

☐ Other_____

Does your pharmacy provide mail delivery services to the patient's home? ☐ Yes ☐ No

Are there any cost billed to members for mail service? ☐ Yes ☐ No

Pharmacy accepts E-Prescribing? ☐ Yes ☐ No

Name of E-Prescribing Vendor: _____

Pharmacy accepts credit card payments? ☐ Yes ☐ No

Name of credit card processor: _____

Pharmacy accepts ATM/Debit card payments? ☐ Yes ☐ No

Name of ATM/Debit card processor: _____

Indicate all languages other than English spoken by staff within this pharmacy:

☐ Arabic ☐ Armenian ☐ Cambodian ☐ Chinese ☐ Farsi ☐ French ☐ Hindi ☐ Indian
☐ Japanese ☐ Korean ☐ Mandarin Chinese ☐ Russian ☐Spanish ☐ Tagalog ☐ Vietnamese
☐ Other_____ ☐ Other_____ ☐ Other_____

Indicate all languages other than English in which prescription drug labels can be provided:

☐ Arabic ☐ Armenian ☐ Cambodian ☐ Chinese ☐ Farsi ☐ French ☐ Hindi ☐ Indian
☐ Japanese ☐ Korean ☐ Mandarin Chinese ☐ Russian ☐Spanish ☐ Tagalog ☐ Vietnamese
☐ Other_____ ☐ Other_____ ☐ Other_____

Is the Pharmacy licensed by the California State Board of Pharmacy as a Licensed Sterile Compounding Pharmacy? ☐ Yes ☐ No

Does pharmacy provide:

Non-sterile compounding products? (such as topical creams, gels, suppositories, capsules, and oral suspensions)	☐ Yes	☐ No
Enteral Nutrients, Equipment, & Supplies	☐ Yes	☐ No
Surgical Dressings	☐ Yes	☐ No
Tracheostomy Supplies	☐ Yes	☐ No
Urological Supplies	☐ Yes	☐ No
Ostomy Supplies	☐ Yes	☐ No

Is the pharmacy accredited by a Centers for Medicare & Medicaid Services (CMS)-approved independent national Accreditation Organization (AO) to supply Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)?
☐ Yes ☐ No

Does pharmacy have an existing contract for the provision of medications to any state-licensed facilities where Patient-Beneficiaries reside (LTC, SNF, ICF, Board and Care)? ☐ Yes ☐ No

If Yes, please list all such facilities (include facility type, name and address);

Facility Type	Facility Name	Facility Address

List any health screenings or other services available at this pharmacy:

_____
_____
_____

Pharmacist in Charge: _____ Lic #: _____ Exp_____

☐ Staff Pharmacist or ☐ Tech: _____ Lic #: _____ Exp _____

☐ Staff Pharmacist or ☐ Tech: _____ Lic #: _____ Exp _____

☐ Staff Pharmacist or ☐ Tech: _____ Lic #: _____ Exp: _____

☐ Staff Pharmacist or ☐ Tech: _____ Lic #: _____ Exp: _____

☐ Staff Pharmacist or ☐ Tech: _____ Lic #: _____ Exp _____

Liability Insurance Carrier: _____

Per Occurrence: $_____ Aggregate: $_____ Expiration Date: _____

Please attach a thorough written explanation for all "yes" responses to the following four questions:

1. Are any of the pharmacies covered by this contract currently operating on a probationary status or with any sanctions imposed by any third party or licensing authority upon their operation? ☐ Yes ☐ No
2. Have any of the pharmacies covered by this contract had their license suspended by a state or federal agency in the past five years? ☐ Yes ☐ No
3. Have any disciplinary actions been imposed in the past three years by any state or federal agency upon the corporate office, any pharmacy, or any employee? ☐ Yes ☐ No
4. Are there any pharmacists currently employed who would NOT be covered by the company's malpractice insurance policy or their own malpractice insurance policy? ☐ Yes ☐ No

Owner(s) Name(s) _____

Owner's Address: _____

City/State/Zip: _____

Does the owner (or owners) also own other pharmacies? ☐ Yes ☐ No

If Yes, please list all other pharmacies by name, NCPDP number and address; attach a separate sheet of paper if necessary:

_____

Federal law, Section 1124 of the Social Security Act (SSA), (42 U.S.C. 1320a-3), requires the disclosure of the identity of each person with an ownership or control interest of 5 percent or more in the disclosing entity, as defined, or in any subcontractor in which the disclosing entity has a direct or indirect ownership of 5 percent or more, as a condition of participation, or continuing participation, in any of the programs established under Title V, XVIII, and XIX. The Medicaid (Medi-Cal) program is established under Title XIX.

I certify that the information in this application is true and correct. I understand that misrepresentation may result in my non-selection, or, if discovered after selection, in my termination as a network provider.

This Information Was Provided By:

_____ _____

Name/Title Date

_____ _____

Signature Telephone

Pharmacy Contact: _____Telephone_____

Please include copies of the following documents:

1. Liability Insurance Certificate
2. Seller's Permit
3. DEA Certificate
4. State Board Inspection (if applicable)

Policy ~~#~~:	GG.1409
Title:	**Drug Formulary Development and Management**
Department:	Medical ~~Affairs~~Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	04/01/99
Revised Date:	~~09/06/18~~
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima shall develop and manage the drug Formulary.

II. POLICY

A. The Formulary development and management process shall ensure Member access to clinically appropriate and cost-effective pharmaceuticals, in accordance with the decisions of the CalOptima Pharmacy and Therapeutics (P&T) Committee, and consistent with the scope of benefits for pharmaceutical services, as established by the California Department of Health Care Services (DHCS) and Title 22 of the California Code of Regulations.

B. CalOptima's Pharmacy Management Department shall delegate daily ~~formulary~~Formulary administrative functions to the Pharmacy Benefit Manager (PBM) and shall ensure that these activities are conducted pursuant to CalOptima policy through oversight and monitoring of the PBM's ~~formulary~~Formulary administrative process.

C. CalOptima's Approved Drug List (Formulary) shall be comparable to the Medi-Cal Fee-For-Service (FFS) contract drug list. Nothing herein shall require CalOptima's Approved Drug List (Formulary) to duplicate the medications, or parameters as contained on the DHCS Contract Drug List.

D. CalOptima's Formulary shall be posted on the CalOptima website in a machine-readable file and format and a printed version shall be made available ~~to the Members~~ upon request if Members or Prescribing Practitioners do not have fax, email or internet access, pursuant to Title 42 Code of Federal Regulations (CFR) Section 438.10(i).

E. CalOptima shall meet DHCS Formulary requirements.

F. On an annual basis, CalOptima Pharmacy Management, with the participation of physicians and pharmacists, shall review and update the Formulary and pharmaceutical management procedures.

G. CalOptima shall post a summary of the changes to the Formulary on the CalOptima website following the quarterly P&T Committee meetings.

Back to Agenda Back to Item

H. CalOptima shall communicate changes and updates relating to the Formulary and pharmaceutical management procedures to Members and Prescribing Practitioners annually, and as needed after Formulary updates to notify them:

1. Where to find the Formulary, including restrictions and preferences such as Step Therapy protocols, on the CalOptima website;

2. How to use the Pharmaceutical Management procedures;

3. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;

4. How Prescribing Practitioners must provide information to support a Prior Authorization request; and

5. Where changes to the Formulary are posted on the CalOptima website.

III. PROCEDURE

A. Formulary Development

1. The CalOptima P&T Committee shall make reasonable effort to review a new chemical entity, new U.S. Food and Drug Administration (FDA) approved drug product, or new FDA approved indication within ninety (90) calendar days after release into the market, and shall make a decision on the ~~formulary~~Formulary status of the drug within one hundred eighty (180) calendar days after its release into the market, or provide a clinical justification if the timeframe is not met.

2. The P&T Committee shall also:

a. Approve all changes and updates to the Formulary;

b. Approve the inclusion, or exclusion, of classes of drugs in the Formulary;

c. On an annual basis, review the therapeutic classes in the Formulary;

d. Consider whether or not the inclusion of a particular drug on the Formulary has any therapeutic advantages in safety and efficacy compared to other drugs in the same class, and the therapeutic advantages of a particular drug in relation to the interaction of a drug therapy regimen and the use of other health care services;

e. Review the Prior Authorization guidelines for drugs;

f. Base clinical decisions on the strength of scientific evidence, standards of practice, and safety and efficacy considerations;

g. Consider use of the following resources to assist in decision-making:

i. Peer-reviewed medical literature;

ii. Randomized clinical trials;

iii. Well-established Clinical Practice Guidelines (CPG);

iv. Pharmacoeconomic studies;

v. Outcomes research data;

vi. Centers for Medicare & Medicaid Services (CMS) policies and guidelines;

vii. Centers for Disease Control and Prevention (CDC) policies and guidelines;

viii. Medi-Cal Manual;

ix. FDA policies and guidelines; and

x. Other information, as appropriate;

h. Meet on a regular basis, but not less than quarterly; and

i. Include a majority of members that are practicing physicians or practicing pharmacists, with:

i. At least one (1) practicing physician and at least one (1) practicing pharmacist that do not have a conflict of interest with respect to CalOptima and pharmaceutical manufacturers;

ii. At least one (1) practicing physician and at least one (1) practicing pharmacist that are independent experts in the care of the elderly, or disabled, persons, and represent:

a) Various clinical specialties that represent the needs of Members; and

b) Are practicing physicians and pharmacists who do not work for CalOptima.

j. Request external review by a Prescribing Practitioner with a specialty, or subspecialty, of medical practice when that specialty is not represented on the P&T Committee when additional expertise is needed.

3. As part of the Formulary decision process, the P&T Committee may elect to set specific ~~drug~~ usage criteria~~, such~~ within each class of pharmaceuticals based on safety, efficacy and cost as follows:

a. Preferred drug status;

b. Contingent therapy;

c. Step Therapy protocols;

d. Non-Formulary status;

~~d.~~e. Duration-of-therapy limits;

~~e.~~f. Age or gender limits;

g. Generic substitution;

~~f.~~h. Strength-related quantity limits; and

~~g.~~i. Therapeutic ~~substitution~~interchange.

4. Decisions and recommendations of the P&T Committee shall be reported to CalOptima's Utilization Management Committee.

5. CalOptima's Pharmacy Management Department shall be responsible for:

   a. Presenting therapeutic drug selection and usage recommendations to the P&T Committee;

   b. Presenting Prior Authorization guidelines for the drugs under review;

   c. Presenting the annual review of therapeutic classes in the Formulary;

   d. Tracking and reporting the resulting pharmacy utilization trends to the P&T Committee for follow-up assessment of the effectiveness and outcomes of the P&T Committee's decisions;

   e. Ensuring that the P&T drug evaluations and P&T minutes contain the criteria used when making a Formulary, or preferred status decision for a drug, or drug class, and how the P&T Committee makes decisions on:

      i. Drug class reviews;

      ii. Drug classes that are preferred or covered at any level;

      iii. The Prior Authorization guidelines ~~for drugs~~within each class of pharmaceuticals which are not preferred or non-Formulary;

      iv. Limiting access to drugs within certain classes; and

      v. Evidence that preferred-status drugs may produce similar, or better, results for the majority of the population compared to other drugs within the same class.

   f. Accepting Member, pharmacist, or Prescribing Provider, requests to add to, or remove, drugs from the Formulary, and reviewing the request at the next P&T meeting; and

   g. Providing at least sixty (60) calendar days' notice to Participating Pharmacies, via facsimile, prior to removing a medication from the Formulary, or making any changes to the preferred status of a drug.

B. Formulary Management

1. The CalOptima Pharmacy Management Department shall be responsible for the overall administration of the Formulary management process. The Pharmacy Management Department shall coordinate activities with other internal departments, as needed, to carry out its administrative responsibilities. Specific responsibilities include, but are not limited to, the following:

   a. Ensuring compliance with DHCS Formulary requirements, which include:

      i. Submitting a complete CalOptima Formulary to DHCS annually for review and approval and any changes to DHCS as File and Use;

ii. Using the Formulary as published, unless DHCS notifies CalOptima of changes that must be made;

iii. Reviewing the CalOptima Formulary to ensure that it is comparable to the Medi-Cal Fee-For-Service (FFS) contract drugs list, except for drugs carved out of the State Contract. For this purpose, "comparable" means:

a) The CalOptima Formulary shall include at least one (1) drug in every therapeutic category or class listed on the Medi-Cal FFS contract drug list within 6 months of its inclusion on the Medi-Cal FFS contract drug list.

b) If CalOptima chooses to subject all drugs within the same therapeutic category to Prior Authorization requirements and one (1) such drug is available on the Medi-Cal FFS contract drug list without treatment authorization request requirements, CalOptima shall submit the following for all drugs of that same mechanism of action:

1) Clinical rationale for such an action; and

2) Criteria used to adjudicate the Prior Authorization request and/or how the approval criteria for the ~~formulary~~Formulary option(s) differ from the non-~~formulary~~Formulary options.

c) A drug not listed on the ~~formulary~~Formulary must be available by Prior Authorization (exception process) for Members and Prescribing Practitioners if deemed Medically Necessary.

iv. Implementing and maintaining a process to ensure that the Formulary is reviewed and updated, no less than quarterly, by the P&T Committee, which will include CalOptima's pharmacists as voting members on the Committee;

v. Ensuring that the review and update considers all drugs approved by the FDA and/or added to the Medi-Cal FFS contract drugs list;

vi. Documenting deletions to the Formulary, and justifying deletions to DHCS; and

vii. Ensuring drug utilization reviews are appropriately conducted by the P&T Committee and pursuant to DHCS guidelines.

b. Pharmacy utilization management tracking and reporting;

c. Assessing and reporting Formulary compliance;

d. Oversight of the PBM in the performance of the online administration of the Formulary;

e. Communication to the PBM regarding Formulary changes;

f. Publication of the Formulary and quarterly updates to the Formulary following the P&T Committee meeting on the CalOptima website: www.caloptima.org, as well as in a print version available to Members and Prescribing Practitioners upon request. CalOptima's drug ~~formulary~~Formulary information shall include:

i. An explanation of what a ~~formulary~~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~~ for Members and Prescribing Practitioners who do not have fax, email, or internet access; 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~~Member and a compound alternative is medically necessary.

3. All FDA-approved tobacco cessation medications including bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch, are available without a Prior Authorization for all adults.

4. Daily operations to implement, maintain, and report compliance with the Formulary shall be delegated to the PBM, and shall be carried out according to CalOptima standards. Delegated activities shall be described in the PBM Services Agreement, and shall include, but not be limited to, the following activities:

    a. Entry and maintenance of the Formulary into the Prior Authorization and claims adjudication systems, as directed by CalOptima and approved by the P&T Committee, including the accompanying preferred drugs, Step Therapy Protocols, Contingent Therapy Protocols, Therapeutic Substitution Protocols, Quantity Limits, and Duration-of-Therapy Limits;

    b. Supervision of online functions to administer the CalOptima approved Step Therapy Protocols, Contingent Therapy Protocols, Duration-of-Therapy Limits, and Quantity Limits, as listed on the Formulary; and

    c. Supervision of online functions to administer CalOptima approved online drug utilization review program and drug-to-drug interaction alerts for drugs not listed on the Formulary.

        i. Drug utilization review edits consist of alerts on duplication of therapy for the same medication, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that duplication of therapy is present and Prior Authorization is required in order to dispense the medication.

        ii. Drug-to-drug interactions, such as Severity Level 1 drug interactions, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that a drug-to-drug interaction is present and shall require a Prior Authorization in order to dispense the medication.

    d. Administration of the Prior Authorization process for non-Formulary medications, in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process;

    e. Claims control processes, e.g., to prevent payment for a non-Formulary medication without entry of a Prior Authorization specific to the medication and the Member to which it has been prescribed.

IV. ATTACHMENT(S)

A. Pharmacy & Therapeutic Committee Roster
B. MedWatch form

V. REFERENCE(S)

A. CalOptima Approved Drug List
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Pharmacy & Therapeutics Committee Roster
~~D. CalOptima Policy AA.1000: Glossary of Terms~~
~~E.~~D. CalOptima Policy GG.1401: Pharmacy Authorization Process
~~F.~~E. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives
~~G.~~F. Department of Health Care Services (DHCS) ~~Policy~~All Plan Letter (~~PL) 14~~APL) 16-014 (Supersedes14-006~~):~~): Comprehensive Tobacco Services for Medi-Cal ~~Members; Preventing Tobacco Use in Children and Adolescent~~Beneficiaries

~~H.~~G. Department of Health Care Services (DHCS) All-Plan Letter (APL) 16-010: Medi-Cal Managed Health Plan Pharmaceutical Formulary Comparability Requirement
~~I.~~H. Health and Safety Code, §1363.01
~~J.~~I. Title 22, California Code of Regulations (CCR), §51003
~~K.~~J. Title 42, Code of Federal Regulations (CFR), §§438.10(d)(6) and (i)

VI. REGULATORY AGENCYAPPROVAL(S)

Date	Regulatory Agency
04/19/16	Department of Health Care Services
03/16/15	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
09/06/18	Regular Meeting of the CalOptima Board of Directors
08/06/20	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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
Revised		GG.1409	Drug Formulary Development and Management	Medi-Cal

IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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~~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~~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 Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	04/01/99
Revised Date:	

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
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Back to Agenda Back to Item

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III. PROCEDURE

A. Formulary Development

1. The CalOptima P&T Committee shall make reasonable effort to review a new chemical entity, new U.S. Food and Drug Administration (FDA) approved drug product, or new FDA approved indication within ninety (90) calendar days after release into the market, and shall make a decision on the Formulary status of the drug within one hundred eighty (180) calendar days after its release into the market, or provide a clinical justification if the timeframe is not met.

2. The P&T Committee shall also:

a. Approve all changes and updates to the Formulary;

b. Approve the inclusion, or exclusion, of classes of drugs in the Formulary;

c. On an annual basis, review the therapeutic classes in the Formulary;

d. Consider whether or not the inclusion of a particular drug on the Formulary has any therapeutic advantages in safety and efficacy compared to other drugs in the same class, and the therapeutic advantages of a particular drug in relation to the interaction of a drug therapy regimen and the use of other health care services;

e. Review the Prior Authorization guidelines for drugs;

f. Base clinical decisions on the strength of scientific evidence, standards of practice, and safety and efficacy considerations;

g. Consider use of the following resources to assist in decision-making:

i. Peer-reviewed medical literature;

ii. Randomized clinical trials;

iii. Well-established Clinical Practice Guidelines (CPG);

iv. Pharmacoeconomic studies;

v. Outcomes research data;

vi. Centers for Medicare & Medicaid Services (CMS) policies and guidelines;

vii. Centers for Disease Control and Prevention (CDC) policies and guidelines;

viii. Medi-Cal Manual;

ix. FDA policies and guidelines; and

x. Other information, as appropriate;

h. Meet on a regular basis, but not less than quarterly; and

i. Include a majority of members that are practicing physicians or practicing pharmacists, with:

i. At least one (1) practicing physician and at least one (1) practicing pharmacist that do not have a conflict of interest with respect to CalOptima and pharmaceutical manufacturers;

ii. At least one (1) practicing physician and at least one (1) practicing pharmacist that are independent experts in the care of the elderly, or disabled, persons, and represent:

a) Various clinical specialties that represent the needs of Members; and

b) Are practicing physicians and pharmacists who do not work for CalOptima.

j. Request external review by a Prescribing Practitioner with a specialty, or subspecialty, of medical practice when that specialty is not represented on the P&T Committee when additional expertise is needed.

3. As part of the Formulary decision process, the P&T Committee may elect to set specific usage criteria within each class of pharmaceuticals based on safety, efficacy and cost as follows:

a. Preferred drug status;

b. Contingent therapy;

c. Step Therapy protocols;

d. Non-Formulary status;

e. Duration-of-therapy limits;

f. Age or gender limits;

g. Generic substitution;

h. Strength-related quantity limits; and

i. Therapeutic interchange.

4. Decisions and recommendations of the P&T Committee shall be reported to CalOptima's Utilization Management Committee.

5. CalOptima's Pharmacy Management Department shall be responsible for:

   a. Presenting therapeutic drug selection and usage recommendations to the P&T Committee;

   b. Presenting Prior Authorization guidelines for the drugs under review;

   c. Presenting the annual review of therapeutic classes in the Formulary;

   d. Tracking and reporting the resulting pharmacy utilization trends to the P&T Committee for follow-up assessment of the effectiveness and outcomes of the P&T Committee's decisions;

   e. Ensuring that the P&T drug evaluations and P&T minutes contain the criteria used when making a Formulary, or preferred status decision for a drug, or drug class, and how the P&T Committee makes decisions on:

      i. Drug class reviews;

      ii. Drug classes that are preferred or covered at any level;

      iii. The Prior Authorization guidelines within each class of pharmaceuticals which are not preferred or non-Formulary;

      iv. Limiting access to drugs within certain classes; and

      v. Evidence that preferred-status drugs may produce similar, or better, results for the majority of the population compared to other drugs within the same class.

   f. Accepting Member, pharmacist, or Prescribing Provider, requests to add to, or remove, drugs from the Formulary, and reviewing the request at the next P&T meeting; and

   g. Providing at least sixty (60) calendar days' notice to Participating Pharmacies, via facsimile, prior to removing a medication from the Formulary, or making any changes to the preferred status of a drug.

B. Formulary Management

1. The CalOptima Pharmacy Management Department shall be responsible for the overall administration of the Formulary management process. The Pharmacy Management Department shall coordinate activities with other internal departments, as needed, to carry out its administrative responsibilities. Specific responsibilities include, but are not limited to, the following:

   a. Ensuring compliance with DHCS Formulary requirements, which include:

      i. Submitting a complete CalOptima Formulary to DHCS annually for review and approval and any changes to DHCS as File and Use;

      ii. Using the Formulary as published, unless DHCS notifies CalOptima of changes that must be made;

iii. Reviewing the CalOptima Formulary to ensure that it is comparable to the Medi-Cal Fee-For-Service (FFS) contract drugs list, except for drugs carved out of the State Contract. For this purpose, "comparable" means:

a) The CalOptima Formulary shall include at least one (1) drug in every therapeutic category or class listed on the Medi-Cal FFS contract drug list within 6 months of its inclusion on the Medi-Cal FFS contract drug list.

b) If CalOptima chooses to subject all drugs within the same therapeutic category to Prior Authorization requirements and one (1) such drug is available on the Medi-Cal FFS contract drug list without treatment authorization request requirements, CalOptima shall submit the following for all drugs of that same mechanism of action:

1) Clinical rationale for such an action; and

2) Criteria used to adjudicate the Prior Authorization request and/or how the approval criteria for the Formulary option(s) differ from the non-Formulary options.

c) A drug not listed on the Formulary must be available by Prior Authorization (exception process) for Members and Prescribing Practitioners if deemed Medically Necessary.

iv. Implementing and maintaining a process to ensure that the Formulary is reviewed and updated, no less than quarterly, by the P&T Committee, which will include CalOptima's pharmacists as voting members on the Committee;

v. Ensuring that the review and update considers all drugs approved by the FDA and/or added to the Medi-Cal FFS contract drugs list;

vi. Documenting deletions to the Formulary, and justifying deletions to DHCS; and

vii. Ensuring drug utilization reviews are appropriately conducted by the P&T Committee and pursuant to DHCS guidelines.

b. Pharmacy utilization management tracking and reporting;

c. Assessing and reporting Formulary compliance;

d. Oversight of the PBM in the performance of the online administration of the Formulary;

e. Communication to the PBM regarding Formulary changes;

f. Publication of the Formulary and quarterly updates to the Formulary following the P&T Committee meeting on the CalOptima website: www.caloptima.org, as well as in a print version available to Members and Prescribing Practitioners 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 for Members and Prescribing Practitioners who do not have fax, email, or internet access; and

v. Indicate that the presence of a drug on CalOptima's Formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing Provider for a particular medical condition.

g. Communication to Participating Pharmacies, Members, and Prescribing Practitioners annually and after updates to the Formulary posted on the CalOptima website for the following:

i. Where to find the Formulary, including restrictions and preferences such as Step Therapy protocols, on the CalOptima website;

ii. How to use the Pharmaceutical Management procedures;

iii. An explanation of Formulary limits and restrictions and the process for Step Therapy protocols;

iv. How Prescribing Practitioners must provide information to support a Prior Authorization request; and

v. Where changes to the Formulary are posted on the CalOptima website.

vi. How the Members or Prescribing Practitioners can obtain a print version of the Formulary.

h. Coordination of the P&T Committee scheduling, agenda, actions, and minutes; and

i. Periodic updates to information published in the Member Handbook as posted on the CalOptima website.

2. CalOptima shall require the use of an FDA-approved and nationally marketed drugs unless a medical necessity can be established requiring the use of a compounded alternative. Compounded products may be dispensed only when an FDA-approved therapeutic equivalent does not exist in the marketplace or when the FDA-approved product does not meet the medical needs of the Member and a compound alternative is medically necessary.

3. All FDA-approved tobacco cessation medications including bupropion SR, Varenicline, nicotine gum, nicotine inhaler, nicotine lozenge, nicotine nasal spray, and the nicotine patch, are available without a Prior Authorization for all adults.

4. Daily operations to implement, maintain, and report compliance with the Formulary shall be delegated to the PBM, and shall be carried out according to CalOptima standards. Delegated activities shall be described in the PBM Services Agreement, and shall include, but not be limited to, the following activities:

a. Entry and maintenance of the Formulary into the Prior Authorization and claims adjudication systems, as directed by CalOptima and approved by the P&T Committee, including the accompanying preferred drugs, Step Therapy Protocols, Contingent Therapy Protocols, Therapeutic Substitution Protocols, Quantity Limits, and Duration-of-Therapy Limits;

b. Supervision of online functions to administer the CalOptima approved Step Therapy Protocols, Contingent Therapy Protocols, Duration-of-Therapy Limits, and Quantity Limits, as listed on the Formulary; and

c. Supervision of online functions to administer CalOptima approved online drug utilization review program and drug-to-drug interaction alerts for drugs not listed on the Formulary.

   i. Drug utilization review edits consist of alerts on duplication of therapy for the same medication, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that duplication of therapy is present and Prior Authorization is required in order to dispense the medication.

   ii. Drug-to-drug interactions, such as Severity Level 1 drug interactions, which generate a rejection at the point of dispensing, and notification to the Participating Pharmacy that a drug-to-drug interaction is present and shall require a Prior Authorization in order to dispense the medication.

d. Administration of the Prior Authorization process for non-Formulary medications, in accordance with CalOptima Policy GG.1401: Pharmacy Authorization Process;

e. Claims control processes, e.g., to prevent payment for a non-Formulary medication without entry of a Prior Authorization specific to the medication and the Member to which it has been prescribed.

IV. ATTACHMENT(S)

A. Pharmacy & Therapeutic Committee Roster
B. MedWatch form

V. REFERENCE(S)

A. CalOptima Approved Drug List
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Pharmacy & Therapeutics Committee Roster
D. CalOptima Policy GG.1401: Pharmacy Authorization Process
E. Department of Health Care Services (DHCS) Policy Letter (PL) 14-002: Requirement to Use Food and Drug Administration Approved Drugs, Rather Than Compounded Alternatives
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 16-014 (Supersedes14-006): Comprehensive Tobacco Services for Medi-Cal Beneficiaries
G. Department of Health Care Services (DHCS) All-Plan Letter (APL) 16-010: Medi-Cal Managed Health Plan Pharmaceutical Formulary Comparability Requirement
H. Health and Safety Code, §1363.01
I. Title 22, California Code of Regulations (CCR), §51003
J. Title 42, Code of Federal Regulations (CFR), §§438.10(d)(6) and (i)

VI. REGULATORY AGENCYAPPROVAL(S)

Date	Regulatory Agency
04/19/16	Department of Health Care Services
03/16/15	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
09/06/18	Regular Meeting of the CalOptima Board of Directors
08/06/20	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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
Revised		GG.1409	Drug Formulary Development and Management	Medi-Cal

IX. GLOSSARY

Term	Definition
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
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.

CalOptima Pharmacy and Therapeutic Committee Roster

Committee Members	Title
Alan Cortez, M.D.	M.D. Pediatric Endocrinology
Curtis Siu, Pharm.D.	Pharm.D., Community Pharmacy
David Ramirez, M.D.	M.D., Chief Medical Officer
Diana Khader, Pharm.D.	Pharm.D., Clinical Pharmacy Manager
Donald Sharps, M.D.	M.D. Psychiatry, Medical Director (Chair)
Emily Fonda, M.D.	M.D. Internal Medicine, Medical Director
Himmet Dajee, M.D.	M.D. Cardiology, Medical Director
Kris Gericke, Pharm.D.	Pharm.D., Clinical Pharmacy Director
Linh Lee, Pharm.D.	Pharm.D., Specialty Pharmacy
Martin Grubin, M.D.	M.D., Family Practice
Nicki Ghazanfarpour, Pharm.D.	Pharm.D., Clinical Pharmacy Manager
Raymond Wang, M.D.	M.D., Pediatric Metabolic Disorder
Robin Corelli, Pharm.D.	Pharm.D., Clinical Pharmacy
Shabnam Eragi, Pharm.D.	Pharm.D, Clinical Pharmacist
Tina Li, Pharm.D.	Pharm.D., Clinical Pharmacy Manager

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U.S. Department of Health and Human Services
Food and Drug Administration

MEDWATCH

FORM FDA 3500 (2/20)
The FDA Safety Information and Adverse Event Reporting Program

For VOLUNTARY reporting of adverse events, product problems and product use/medication errors

Form Approved: OMB No. 0910-0291, Expires: 11-30-2021
See PRA statement on reverse.

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-2018.

A. PATIENT INFORMATION

1. **Patient Identifier**
In Confidence

2. **Age**
☐ Year(s) ☐ Month(s) ☐ Week(s) ☐ Day(s)
or Date of Birth *(e.g., 08 Feb 1925)*

3. **Gender** *(check one)*
☐ Female ☐ Male ☐ Intersex ☐ Transgender ☐ Prefer not to disclose

4. **Weight**
☐ lb ☐ kg

5. **Ethnicity** *(check one)*
☐ Hispanic/Latino ☐ Not Hispanic/Latino

6. **Race** *(check all that apply)*
☐ Asian ☐ American Indian or Alaskan Native ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

B. ADVERSE EVENT, PRODUCT PROBLEM

1. **Type of Report** *(check all that apply)*
☐ Adverse Event ☐ Product Problem *(e.g., defects/malfunctions)*
☐ Product Use/ Medication Error ☐ Problem with Different Manufacturer of Same Medicine

2. **Outcome Attributed to Adverse Event** *(check all that apply)*
☐ Death *Date of death (dd-mmm-yyyy):*
☐ Life-threatening ☐ Disability or Permanent Damage
☐ Hospitalization (initial or prolonged) ☐ Congenital Anomaly/Birth Defects
☐ Other Serious or Important Medical Events
☐ Required Intervention to Prevent Permanent Impairment/Damage

3. **Date of Event** *(dd-mmm-yyyy)*

4. **Date of this Report** *(dd-mmm-yyyy)*

5. **Describe Event, Problem or Product Use/Medication Error**

(Continue on page 2)

6. **Relevant Tests/Laboratory Data** **Date** *(dd-mmm-yyyy)*

(Continue on page 2)

7. **Other Relevant History, Including Preexisting Medical Conditions** *(e.g., allergies, pregnancy, smoking and alcohol use, liver/kidney problems, etc.)*

(Continue on page 2)

C. PRODUCT AVAILABILITY

1. **Product Available for Evaluation?** *(Do not send product to FDA)*
☐ Yes ☐ No ☐ Returned to Manufacturer on *(dd-mmm-yyyy)*

2. **Do you have a picture of the product?** *(check yes if you are including a picture)* ☐ Yes

D. SUSPECT PRODUCTS

1. **Name, Strength, Manufacturer/Compounder** *(from product label).*
Does this report involve cosmetic, dietary supplement or food/medical food? **#1** ☐ Yes **#2** ☐ No

#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 #

2. **Dose or Amount** | **Frequency** | **Route**

#1			
#2			

3. **Treatment Dates/Therapy Dates** *(give best estimate of length of treatment (start/stop) or duration.)*
#1 Start
#1 Stop
Is therapy still on-going? ☐ Yes ☐ No
#2 Start
#2 Stop
Is therapy still on-going? ☐ Yes ☐ No

4. **Diagnosis for Use** *(Indication)*
#1
#2

5. **Product Type** *(check all that apply)*
#1 ☐ OTC ☐ Compounded ☐ Generic ☐ Biosimilar
#2 ☐ OTC ☐ Compounded ☐ Generic ☐ Biosimilar

6. **Expiration Date** *(dd-mmm-yyyy)*
#1
#2

7. **Event Abated After Use Stopped or Dose Reduced?**
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

8. **Event Reappeared After Reintroduction?**
#1 ☐ Yes ☐ No ☐ Doesn't apply
#2 ☐ Yes ☐ No ☐ Doesn't apply

E. SUSPECT MEDICAL DEVICE

1. **Brand Name**

2a. **Common Device Name** 2b. **Procode**

3. **Manufacturer Name, City and State**

4. **Model #** **Lot #**
Catalog # **Expiration Date** *(dd-mmm-yyyy)*
Serial # **Unique Identifier** *(UDI)* **#**

5. **Operator of Device**
☐ Health Professional ☐ Patient/Consumer ☐ Other

6a. **If Implanted, Give Date** *(dd-mmm-yyyy)* 6b. **If Explanted, Give Date** *(dd-mmm-yyyy)*

7a. **Is this a single-use device that was reprocessed and reused on a patient?** ☐ Yes ☐ No

7b. **If Yes to Item 7a, Enter Name and Address of Reprocessor**

8. **Was this device serviced by a third party servicer?**
☐ Yes ☐ No ☐ Unknown

F. OTHER (CONCOMITANT) MEDICAL PRODUCTS

1. **Product names and therapy dates** *(Exclude treatment of event)*

(Continue on page 2)

G. REPORTER *(See confidentiality section on back)*

1. **Name and Address**
Last Name: First Name:
Address:
City: State/Province/Region:
ZIP/Postal Code: Country:
Phone #: Email:

2. **Health Professional?** ☐ Yes ☐ No

3. **Occupation**

4. **Also Reported to:**
☐ Manufacturer/ Compounder ☐ User Facility ☐ Distributor/Importe

5. **If you do NOT want your identity disclosed to the manufacturer, please mark this box:** ☐

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U.S. Department of Health and Human Services
Food and Drug Administration

MEDWATCH

FORM FDA 3500 (2/20) *(continued)*
The FDA Safety Information and Adverse Event Reporting Program

(CONTINUATION PAGE)
For VOLUNTARY reporting of adverse events, product problems and product use/medication errors

B.5. **Describe Event or Problem** *(continued)*

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B.6. **Relevant Tests/Laboratory Data** *(continued)*

Date *(dd-mmm-yyyy)*	**Relevant Tests/Laboratory Data**	**Date** *(dd-mmm-yyyy)*

Additional comments

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B.7. **Other Relevant History** *(continued)*

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F.1. **Concomitant Medical Products and Therapy Dates** *(Exclude treatment of event) (continued)*

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ADVICE ABOUT VOLUNTARY REPORTING

Detailed instructions available at: **https://www.fda.gov/safety/medwatch-forms-fda-safety-reporting/instructions-completing-form-fda-3500**

Report adverse events, product problems or product use errors with:

- Medications (drugs or biologics)
- Medical devices (including diabetes glucose-test kit, hearing aids, breast pumps, and many more)
- Combination products (medication & medical devices)
- Blood transfusions, gene therapies, and human cells and tissue transplants (for example, tendons, bone, and corneas)
- Special nutritional products (dietary supplements, medical foods, infant formulas)
- Cosmetics (such as moisturizers, makeup, shampoos and conditioners, face and body washes, deodorants, nail care products, hair dyes and relaxers, and tattoos)
- 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
- Other serious (important medical events)

Report even if:

- You're not certain the product caused the event
- You don't have all the details
- Just fill in the sections that apply to your report

How to 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)

How to submit report:

- To report by phone, call toll-free: 1-800-FDA (332)-1088
- To fax report: 1-800-FDA(332)-0178
- To report online: www.fda.gov/medwatch/report.htm

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 an adverse event with a vaccine, go to http://vaers.hhs.gov to report or call 1-800-822-7967.

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.

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
Office of Chief Information Officer
Paperwork Reduction Act (PRA) Staff
PRAStaff@fda.hhs.gov

Please DO NOT RETURN this form to the PRA Staff e-mail above.

OMB statement:

"An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number."

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Food and Drug Administration

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Policy #:	GG.1410
Title:	**Appeal Process for Pharmacy Authorization**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	05/01/2008
Revised Date:	

Applicable to:
- ☒ Medi-Cal
- ☐ OneCare
- ☐ OneCare Connect
- ☐ PACE
- ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service, or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall process requests for Appeals using the definition, turn-around time, and notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit~~.~~ (Attachment D). A request marked as an Urgent Request that does not meet the definition for expedited review shall be reclassified as a routine request as outlined in this attachment. CalOptima shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the Appeal process to facilitate delivery of appropriate services.

B. Upon receipt of a Notice of Action (NOA) notifying a Prescribing Practitioner or a Member of a CalOptima pharmacy decision that a Pharmaceutical Service request has been ~~modified;~~Modified, denied~~;~~, carved out of a treatment~~;~~, or terminated, reduced, or suspended, a Prescribing Practitioner, a Member, or an Authorized Representative, including an attorney, shall have the right to Appeal the decision.

C. A pharmacy Appeal shall be a separate process from the Provider Complaint, Member Complaint, or Member State Fair Hearing, as specified in CalOptima Policies GG.1510: Appeal~~s~~ Process ~~for Decisions Regarding Care and Services~~, HH.1101: CalOptima Provider Complaint, HH.1102: ~~CalOptima~~ Member ~~Complaint~~Grievance, and HH.1108: State Hearings Process and Procedures.

D. If the Member wishes to have an Authorized Representative act on the Member's behalf in the ~~appeals~~Appeals process, a Member must authorize the appointment, in writing, of an Authorized Representative to represent the Member in the Appeal process, or the Authorized Representative shall submit a copy of a Durable Power of Attorney for health care, or similar legal appointment or representative document, or must otherwise be recognized under California law as a legal representative of the Member.

E. A Prescribing Practitioner on behalf of the Member, the Member, or the Member's Authorized Representative may request a pharmacy Appeal by submitting a written or verbal Appeal request

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within sixty (60) calendar days from the date written on the NOA received from CalOptima, in accordance with the provisions of this policy. Appeals filed by the Prescribing Practitioner on behalf of the Member shall require written consent from the Member.

F. CalOptima shall document the reason for the Appeal, who requested the Appeal, how the Appeal was received, and any actions taken on the ~~appeal~~Appeal.

G. CalOptima shall ensure prompt review and full investigation of the substance for an Appeal, including any aspects of clinical care involved.

H. CalOptima shall give a Member, Authorized Representative or Provider a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, facts, and law in support of the Appeal. In the case of an Appeal subject to an expedited review, CalOptima shall inform the Member, Authorized Representative or Provider of the limited time available to present evidence.

I. ~~The~~CalOptima shall ensure that the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

J. CalOptima shall ensure that at least one person reviewing the Appeal who is a practitioner in the same or similar specialty.

K. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process.

L. A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution if:

1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing date of the NOA;

2. The authorized Prescribing Practitioner orders the medication;

3. The pharmacy Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4. The period covered by the original authorization has not expired; and

5. The Member verbally requests an extension of the benefits by calling the CalOptima Customer Service Department.

~~M. CalOptima may extend the timeframe to resolve the Appeal by up to fourteen (14) calendar days at the request of the Member or if there is a need for additional information and how the delay is in the Member's best interest.~~

~~N. For any extensions not requested by the Member, CalOptima must provide the Member with written notice of the reason for the delay and the right to file a Grievance within two (2) calendar days from the oral notification of the extension.~~

~~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.

~~P.~~N. CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution of an expedited Appeal.

~~Q.~~O. 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.

~~R.~~P. ~~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.~~2. 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.~~3. Oral Appeal requests, excluding expedited Appeals, from a Member, or their Authorized Representative, or a Prescribing Practitioner shall be followed by a written and signed Appeal request. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima

shall provide the Appeal Form to the Member along with the acknowledgement notice. In the event that CalOptima does not receive a written and signed Appeal from the Member, CalOptima shall neither dismiss nor delay resolution of the Appeal.

~~5.~~4. CalOptima shall ensure that the Member or Authorized Representative, is given a reasonable opportunity to present, in writing or verbally, comments, documents or other information relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy Appeal. A Prescribing Practitioner may also contact a CalOptima physician, or a health care professional reviewer, to discuss the NOA for ~~modification~~Modification, denial, termination, or carve out of a service, or to obtain a copy of the criteria used to make the decision. In the case of a pharmacy Appeal subject to expedited review, the CalOptima Customer Service Department or the CalOptima Pharmacy Management Department shall inform the Member or Authorized Representative of the limited time available to present evidence.

~~6.~~5. Upon request by the Member, Authorized Representative, or Prescribing Practitioner, CalOptima shall provide the opportunity, before and during the Appeals process, to examine or obtain a copy of the Member's case file, including medical records, and any other relevant documents and records considered during the Appeals process, free of charge and sufficiently in advance of the resolution timeframe for Appeal.

~~7.~~6. CalOptima shall provide written acknowledgement to the Member, dated and postmarked within five (5) calendar days of the receipt of a standard Appeal request.

~~8.~~7. CalOptima shall process ~~appeals~~Appeals based on the following timeframes:

a. The decision for a pre-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

b. The decision for a post-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

c. The decision for an expedited ~~appeal~~Appeal and notification to the Prescribing Practitioner and Member shall be made within seventy-two (72) hours, or as soon as a ~~Member's~~Member's health condition requires, after the receipt of the request.

~~d. The plan may extend the Appeal timeframe for either standard or expedited Appeals by up to fourteen (14) calendar days if either of these two (2) conditions apply:~~

~~i. The Member requests the extension.~~

~~ii. CalOptima demonstrates to the satisfaction of DHCS, upon request, that there is a need for additional information and the delay is in the Member's best interest.~~

~~e. For any extension not requested by the Member, CalOptima shall provide the Member with written notice of the reason for the delay within two (2) calendar days and notify the Member of the right to file a Grievance if the Member disagrees with the extension.~~

~~f. CalOptima shall make reasonable efforts to provide the Member with oral notice of the extension.~~

~~g. CalOptima shall resolve the Appeal as expeditiously as the Member's health condition requires, but in no event may extend resolution beyond the initial fourteen (14) calendar day extension.~~

~~h.~~d. In the event that CalOptima fails to adhere to the notice and timing requirements of an Appeal, the Member is deemed to have exhausted the CalOptima internal Appeal process and may initiate a State Hearing request.

~~9.~~8. 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~~.~~ (Attachment D).

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~~Letter 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~~It shall also include the nondiscrimination notice and the language assistance taglines.

   b. Oral Appeals from Members, excluding expedited Appeals, shall be followed by a written, signed Appeal. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Member with an Appeal form along with the ~~Member's~~Member's written acknowledgement notification. In the event that CalOptima does not receive a written, signed Appeal from the ~~member~~Member, CalOptima shall neither dismiss or delay the resolution of the Appeal.

   c. Review the initial Pharmacy decision and all documents related to the determination of Medical Necessity of the service requested, including any additional information supplied by the Member, the Member's Authorized Representative, or the Prescribing Practitioner.

   d. Prepare the case file for review by a new health care professional reviewer who was not involved in the initial decision, except if the decision is found fully in favor of the Member, in which case the person making the initial decision may reverse the prior decision.

   e. A CalOptima Clinical Pharmacist shall:

      i. Fully investigate the content of the Appeal without giving deference to the previous denial decision;

      ii. Document the substance of the Appeal, including any aspects of clinical care involved;

      iii. Document the findings of their Appeal review; and

      iv. Document the reasons for the Appeal decision if upheld or overturned.

f. A CalOptima Clinical Pharmacist, or Medical Director, may reverse a denial decision and overturn an Appeal. For Appeal requests that do not meet the CalOptima Clinical Guidelines, the CalOptima Clinical Pharmacist shall send a recommendation to a Medical Director to review for a potential ~~appeal~~Appeal upheld decision.

g. CalOptima ~~may~~shall utilize a specialist health care professional consultant in the same or similar specialty that typically treats the Medical Condition and treating complications that may result from the service or procedure, as appropriate.

2. CalOptima Pharmacy Management Department shall process an expedited Appeal as standard Appeal timeframe, if the Appeal request does not meet the criteria for expedited review.

a. An expedited Appeal may be granted, if a standard Appeal timeframe:

i. Could seriously jeopardize the life or~~,~~ health ~~or safety~~ of the Member or ~~others, due to the Member's psychological state~~the Member's ability to regain maximum function, based on a prudent layperson's judgment;~~,~~ 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~~Appeal status change to standard ~~appeal~~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~~Member's right to request for a State Hearing within one hundred twenty (120) calendar days from the date of on the NAR.

d. The NAR shall include the following information:

i. The results of the resolution and the date it was completed.

ii. For denial determination based in whole or in part on ~~medical necessity~~Medical Necessity, CalOptima shall include clear and concise reason ~~reasons~~(s) 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~~Department of Health Care Services (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.

iv. The titles and qualifications, specialty (for ~~appeal~~Appeal upheld decision), and contact information of the individual healthcare practitioners participating in the ~~appeal~~Appeal review and in the decision of the ~~appeal~~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. ATTACHMENT(S)

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.~~C. CalOptima Policy DD.2002: Cultural and Linguistic Services
D. CalOptima Policy GG.1401: Pharmacy Authorization Process
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510: Appeal~~s~~ Process ~~for Decisions Regarding Care and Services~~
G. CalOptima Policy HH.1101: CalOptima Provider Complaint
H. CalOptima Policy HH.1102: ~~CalOptima~~ Member ~~Complaint~~ Grievance
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~~023: California Children's Services Whole Child Model Program
P. Hannah Robins, Chief DHCS Compliance Unit. DHCS Clarification: Appeal Resolution Timeframes. September 17, 2018.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
08/09/16	Department of Health Care Services
04/26/16	Department of Health Care Services
08/11/14	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
09/06/18	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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

Action	Date	Policy	Policy Title	Program(s)
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
Revised		GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal

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 request by the Member or the Member's Authorized Representative or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denials, or discontinuation of a Covered Service. ~~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~~Adverse Benefit Determination.
Authorized Representative	~~Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations.~~ A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009A: Access by Member's Personal Representative.~~
Covered Service	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~~,~~), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with ~~Section 6840, which~~section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), ~~and~~ speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members ~~not withstanding~~notwithstanding 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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Term	Definition
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, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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 (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.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.~~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.~~
Urgent Request	A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations: 1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Policy #:	GG.1410
Title:	**Appeal Process for Pharmacy Authorization**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	05/01/2008
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy defines the process by which CalOptima addresses and resolves a Pre-service, Post-service, or expedited Appeal for Pharmaceutical Services, in accordance with applicable statutory, regulatory, and contractual requirements.

II. POLICY

A. CalOptima shall process requests for Appeals using the definition, turn-around time, and notification standards as specified in the Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals under the Pharmacy Benefit (Attachment D). A request marked as an Urgent Request that does not meet the definition for expedited review shall be reclassified as a routine request as outlined in this attachment. CalOptima shall maintain appropriate communication with the Prescribing Practitioner and/or Member or the Member's Authorized Representative throughout the Appeal process to facilitate delivery of appropriate services.

B. Upon receipt of a Notice of Action (NOA) notifying a Prescribing Practitioner or a Member of a CalOptima pharmacy decision that a Pharmaceutical Service request has been Modified, denied, carved out of a treatment, or terminated, reduced, or suspended, a Prescribing Practitioner, a Member, or an Authorized Representative, including an attorney, shall have the right to Appeal the decision.

C. A pharmacy Appeal shall be a separate process from the Provider Complaint, Member Complaint, or Member State Fair Hearing, as specified in CalOptima Policies GG.1510: Appeal Process, HH.1101: CalOptima Provider Complaint, HH.1102: Member Grievance, and HH.1108: State Hearings Process and Procedures.

D. If the Member wishes to have an Authorized Representative act on the Member's behalf in the Appeals process, a Member must authorize the appointment, in writing, of an Authorized Representative to represent the Member in the Appeal process, or the Authorized Representative shall submit a copy of a Durable Power of Attorney for health care, or similar legal appointment or representative document, or must otherwise be recognized under California law as a legal representative of the Member.

Back to Agenda Back to Item

E. A Prescribing Practitioner on behalf of the Member, the Member, or the Member's Authorized Representative may request a pharmacy Appeal by submitting a written or verbal Appeal request within sixty (60) calendar days from the date written on the NOA received from CalOptima, in accordance with the provisions of this policy. Appeals filed by the Prescribing Practitioner on behalf of the Member shall require written consent from the Member.

F. CalOptima shall document the reason for the Appeal, who requested the Appeal, how the Appeal was received, and any actions taken on the Appeal.

G. CalOptima shall ensure prompt review and full investigation of the substance for an Appeal, including any aspects of clinical care involved.

H. CalOptima shall give a Member, Authorized Representative or Provider a reasonable opportunity to present, in writing or in person, before the individual(s) resolving the Appeal, evidence, facts, and law in support of the Appeal. In the case of an Appeal subject to an expedited review, CalOptima shall inform the Member, Authorized Representative or Provider of the limited time available to present evidence.

I. CalOptima shall ensure that the person making the final decision for the proposed resolution of an Appeal has neither participated in any prior decisions related to the Appeal, nor is a subordinate of someone who has participated in a prior decision and has clinical expertise in treating the Member's condition or disease if deciding on any of the following:

1. An Appeal of a denial based on lack of Medical Necessity; and

2. Any Appeal involving clinical issues.

J. CalOptima shall ensure that at least one person reviewing the Appeal who is a practitioner in the same or similar specialty.

K. Members shall exhaust CalOptima's Appeal process prior to requesting a State Hearing, in accordance with CalOptima Policy HH.1108: State Hearing Process.

L. A Member may receive continuation of benefits while the pharmacy Appeal is pending resolution if:

1. The Member files the pharmacy Appeal request within ten (10) calendar days of the mailing date of the NOA;

2. The authorized Prescribing Practitioner orders the medication;

3. The pharmacy Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

4. The period covered by the original authorization has not expired; and

5. The Member verbally requests an extension of the benefits by calling the CalOptima Customer Service Department.

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.

N. CalOptima shall make reasonable efforts to provide oral notification to the Member of the resolution of an expedited Appeal.

O. 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.

P. 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. 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.

3. 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.

4. CalOptima shall ensure that the Member or Authorized Representative, is given a reasonable opportunity to present, in writing or verbally, comments, documents or other information relating to the pharmacy Appeal, including evidence, facts, and law in support of the pharmacy Appeal. A Prescribing Practitioner may also contact a CalOptima physician, or a health care professional reviewer, to discuss the NOA for Modification, denial, termination, or carve out of a service, or to obtain a copy of the criteria used to make the decision. In the case of a pharmacy Appeal subject to expedited review, the CalOptima Customer Service Department or the CalOptima Pharmacy Management Department shall inform the Member or Authorized Representative of the limited time available to present evidence.

5. Upon request by the Member, Authorized Representative, or Prescribing Practitioner, CalOptima shall provide the opportunity, before and during the Appeals process, to examine or obtain a copy of the Member's case file, including medical records, and any other relevant documents and records considered during the Appeals process, free of charge and sufficiently in advance of the resolution timeframe for Appeal.

6. CalOptima shall provide written acknowledgement to the Member, dated and postmarked within five (5) calendar days of the receipt of a standard Appeal request.

7. CalOptima shall process Appeals based on the following timeframes:

   a. The decision for a pre-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

   b. The decision for a post-service Appeal and notification to the Prescribing Practitioner and Member shall be made within thirty (30) calendar days of the initial receipt of the request.

   c. The decision for an expedited Appeal and notification to the Prescribing Practitioner and Member shall be made within seventy-two (72) hours, or as soon as a Member's health condition requires, after the receipt of the request.

   d. 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.

8. 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 (Attachment D).

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 Letter 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. It shall also include the nondiscrimination notice and the language assistance taglines.

   b. Oral Appeals from Members, excluding expedited Appeals, shall be followed by a written, signed Appeal. The date of the oral Appeal shall establish the filing date for the Appeal. CalOptima shall provide the Member with an Appeal form along with the Member's written acknowledgement notification. In the event that CalOptima does not receive a written, signed Appeal from the Member, CalOptima shall neither dismiss or delay the resolution of the Appeal.

c. Review the initial Pharmacy decision and all documents related to the determination of Medical Necessity of the service requested, including any additional information supplied by the Member, the Member's Authorized Representative, or the Prescribing Practitioner.

d. Prepare the case file for review by a new health care professional reviewer who was not involved in the initial decision, except if the decision is found fully in favor of the Member, in which case the person making the initial decision may reverse the prior decision.

e. A CalOptima Clinical Pharmacist shall:

i. Fully investigate the content of the Appeal without giving deference to the previous denial decision;

ii. Document the substance of the Appeal, including any aspects of clinical care involved;

iii. Document the findings of their Appeal review; and

iv. Document the reasons for the Appeal decision if upheld or overturned.

f. A CalOptima Clinical Pharmacist, or Medical Director, may reverse a denial decision and overturn an Appeal. For Appeal requests that do not meet the CalOptima Clinical Guidelines, the CalOptima Clinical Pharmacist shall send a recommendation to a Medical Director to review for a potential Appeal upheld decision.

g. CalOptima shall utilize a specialist health care professional consultant in the same or similar specialty that typically treats the Medical Condition and treating complications that may result from the service or procedure, as appropriate.

2. CalOptima Pharmacy Management Department shall process an expedited Appeal as standard Appeal timeframe, if the Appeal request does not meet the criteria for expedited review.

a. An expedited Appeal may be granted, if a standard Appeal timeframe:

i. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment; or

ii. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

b. CalOptima's Pharmacy Management Department shall document and notify the Prescribing Practitioner of the Appeal status change to standard Appeal.

3. Pharmacy Notice of Appeal Resolution (NAR)

a. The CalOptima Pharmacy Management Department shall mail the Member and the Prescribing Practitioner a Notice of Appeal Resolution (NAR) for all Pharmaceutical Services Appeal requests.

b. The NAR shall include information as described in this Section.

c. If CalOptima upholds a pharmacy decision for a Pharmaceutical Service based in whole or in part on findings that the Pharmaceutical Service is not Medically Necessary or not a Covered Service, the NAR shall clearly specify the applicable reference that excludes that service along with the Member's right to request for a State Hearing within one hundred twenty (120) calendar days from the date of on the NAR.

d. The NAR shall include the following information:

i. The results of the resolution and the date it was completed.

ii. For denial determination based in whole or in part on Medical Necessity, CalOptima shall include clear and concise reason(s) 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 Department of Health Care Services (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.

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. ATTACHMENT(S)

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 DD.2002: Cultural and Linguistic Services
D. CalOptima Policy GG.1401: Pharmacy Authorization Process
E. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
F. CalOptima Policy GG.1510: Appeal Process
G. CalOptima Policy HH.1101: CalOptima Provider Complaint
H. CalOptima Policy HH.1102: Member Grievance
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, 18-023: California Children's Services Whole Child Model Program
P. Hannah Robins, Chief DHCS Compliance Unit. DHCS Clarification: Appeal Resolution Timeframes. September 17, 2018.

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
08/09/16	Department of Health Care Services
04/26/16	Department of Health Care Services
08/11/14	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting
09/06/18	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
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

Action	Date	Policy	Policy Title	Program(s)
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
Revised		GG.1410	Appeal Process for Pharmacy Authorization	Medi-Cal

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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 request by the Member or the Member's Authorized Representative, or Provider for review of an Adverse Benefit Determination that involves the delay, modification, denials, or discontinuation of a Covered Service.
Appeal Resolution	An outcome for appeal request as a result of an Adverse Benefit Determination.
Authorized Representative	A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members notwithstanding 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.
Department of Health Care Services (DHCS)	The single State Department responsible for administration of the Medi-Cal program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary services to protect life, to prevent significant illness or significant disability, alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, achieve age-appropriate growth and development, and attain, or regain functional capacity. For Medi-Cal Members receiving managed long-term services and supports (MLTSS), Medical Necessity is determined in accordance with Member's current needs assessment and consistent with person-centered planning. When determining Medical Necessity of Covered Services for Medi-Cal Members under the age of 21, Medical Necessity is expanded to include the standards set forth in 42 U.S.C. section 1396d(r) and California Welfare and Institutions Code section 14132(v).
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 (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.
Provider	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who are licensed to furnish Covered Services.
Urgent Request	A request for pharmaceutical services where application of the time frame for making routine or non-life-threatening care determinations: 1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

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Medi-Cal CalOptima
A Public Agency
Better. Together.

FACSIMILE TRANSMITTAL

Date: «Current_Date»	
To: «Prescriber_Name_First_Name_Last_Name»	**From:** Pharmacy Management Department
Prescriber Fax: «Prescriber_Fax»	**Phone:** (714) 246-8471
Pharmacy Fax: «Rx_Fax»	**Fax:** (714) 954-2280
Subject: «Appeal_Type» Pharmacy Appeal Request	

CONFIDENTIAL: If you receive this fax in error please call CalOptima immediately at (888) 807-5705.

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«Prescriber_Name_First_Name_Last_Name»
«Prescriber_Address»
«Prescriber_City», «Prescriber_State» «Presciber_Zip_Code»

Reference #: «Appeal_ID»
«Current_Date»
Provider: Dr. «Prescriber_Name_First_Name_Last_Name»
Member Name: «Mbr_Name_First_Name_Last_Name»
Member ID#: «Mbr_ID»

RE: «Drug_Name», «Qty» per «Days_Supply» days

CalOptima is issuing a Notice of Appeal Resolution letter regarding a recent request that was submitted.

Attached is a copy of the “Notice of Appeal Resolution” letter sent to a CalOptima member under your care.

If the treating physician would like to discuss this case with the health care professional reviewer or obtain a copy of the criteria used to make this decision, please call the CalOptima Pharmacy Management Department at (714) 246-8471.

If you disagree with this decision, you may file a complaint with CalOptima by writing to:

CalOptima Grievance & Resolution Services
505 City Parkway West
Orange, CA 92868

Thank you,

«MD_Decision_Maker_Upheld_Only»
«Medical_Director_Specialty_HD__Cardio»
«Medical_Director_Title_____HD__»
Phone number: (714) 246-8471

Appeal ID: «Appeal_ID»

NOTICE OF APPEAL RESOLUTION

«Current_Date»

«Mbr_Name_First_Name_Last_Name»
«Address»
«City», «State» «Zip_Code»

«Prescriber_Name_First_Name_Last_Name»
«Prescriber_Address»
«Prescriber_City», «Prescriber_State»
«Presciber_Zip_Code»

Member Identification Number: «Mbr_ID»

RE: «Drug_Name», «Qty» for «Days_Supply» days

You or «Prescriber_Name_First_Name_Last_Name», on your behalf, appealed the «Previous_PA_Status» of «Drug_Name», «Qty» for «Days_Supply». Our Clinical Pharmacist and our Medical Director, who is a physician and board certified in «Medical_Director_Specialty_HD__Cardio», have reviewed the appeal and have decided to uphold the decision. This request is still denied. This is because «Rationale_overturn_upheld»
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 **1-888-587-8088**.

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 **1-888-587-8088**.

This notice does not affect any of your other Medi-Cal services.

CalOptima Pharmacy Management

Enclosed: "Your Rights under Medi-Cal Managed Care"

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

If you still do not agree with this decision, you can ask for a **"State Hearing"** and a judge will review your case.

You must ask for a State Hearing within **120 days** from the date of this "Notice of Appeal Resolution" letter. But, **if you are currently getting treatment and you want to continue getting treatment, you must ask for a State Hearing within 10 days** from the date this letter was postmarked or delivered to you, OR before the date your health plan says services will stop. You must say that you want to keep getting treatment when you ask for the State Hearing. You will not have to pay for a State Hearing.

You can ask for a State Hearing by phone or in writing:

- By phone: Call **1-800-952-5253**. This number can be very busy. You may get a message to call back later. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.

- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  A State Hearing form is included with this letter. Be sure to include your name, address, telephone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. Ask your doctor or health plan to write a letter for you. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an **"expedited hearing"** and provide the letter with your request for a hearing.

You may speak at the State Hearing yourself. Or, someone like a relative, friend, advocate, doctor, or attorney can speak for you. If you want another person to speak

for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an “authorized representative.”

LEGAL HELP

You may be able to get free legal help. Call the Orange County Health Consumer Action Center at 1-800-834-5001. You may also call the local Legal Aid Society in your county at 1-888-804-3536.

FORM TO FILE A STATE HEARING

You can ask for a State Hearing by calling: 1-800-952-5253.
TDD users, call 1-800-952-8349.
Or you can fill out this form and FAX it to State Hearing Support at 916-651-5210 or 916-651-2789.

Or you can mail this page to: California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 9-17-37
Sacramento, CA 94244-2430

For free help filling out this form, call the legal help phone number listed on "Your Rights."

I do not agree with the decision about my health care. Here's why:

_____
_____
_____
_____
_____

(If you need more space, use another piece of paper. Make a copy for your records.)

Check these boxes only if they apply to you:

(1) ❒ I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to the hearing, and speak for me.
Name: _____
Address: _____ Phone Number: _____
_____

(2) ❒ I need a free interpreter. My language or dialect is: _____

(3) ❒ I also want to file a grievance against the health plan. I understand the state will send my health plan a copy of this form.

(4) ❒ My situation is **urgent**. I need a quick decision and cannot wait 90 days because: (Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

_____
_____
_____
_____

(5) ❒ Please continue the service my plan has stopped until my hearing.
My Name: _____ My Social Security Number: _____
Address: _____
_____ Phone Number: _____

My Signature: _____ Today's Date: _____

(After you complete this form, make a copy for your records.)

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NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

  ✓ Qualified sign language interpreters
  ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

  ✓ Qualified interpreters
  ✓ Information written in other languages

If you need these services, contact CalOptima between 8 a.m. - 5:30 p.m. by calling **1-888-587-8088**. Or, if you cannot hear or speak well, please call **TTY/TDD 1-800-735-2929**.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8 a.m. - 5:30 p.m. by calling **1-888-587-8088**. Or, if you cannot hear or speak well, please call **TTY/TDD 1-800-735-2929**.

- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima
  505 City Parkway West
  Orange, CA 92868

- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.

- Electronically: Visit CalOptima's website at www.CalOptima.org.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1-888-587-8088 (TTY: 1-800-735-2929)**.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-587-8088 (TTY: 1-800-735-2929)**.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-587-8088 (TTY: 1-800-735-2929).**

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung ikaw ay nagsasalita sa wikang Tagalog, may mga serbisyo sa pananalita na makakatulong sa iyo na maari mong gamitin nang walang bayad. Tumawag sa **1-888-587-8088 (TTY: 1-800-735-2929)**.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-888-587-8088 (TTY: 1-800-735-2929)번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您说繁體中文，您可以免費獲得語言援助服務。請致電
1-888-587-8088（TTY：1-800-735-2929）。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929)**:

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-587-8088 (телетайп: 1-800-735-2929)**.

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با شماره **1-888-587-8088 (TTY: 1-800-735-2929)** تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-587-8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEBTOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, pab dawb rau koj. Hu rau **1-888-587-8088 (TTY: 1-800-735-2929)**.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-888-587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على رقم **1-888-587-8088 (TTY: 1-800-735-2929).**

हिंदी (Hindi)
ध्यान दें : यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध हैं।
1-888-587-8088 (TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)
ข้อควรคำนึง: ถ้าหากคุณพูดภาษาไทย, คุณสามารถใช้บริการความช่วยเหลือทางภาษา, โดยไม่เสียค่าใช้จ่ายใด ๆ ได้โดย, โทร
1-888-587-8088 (TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)
ចំណុចសំខាន់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយផ្នែកភាសាគឺមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅកាន់លេខ
1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ,
ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໄດ້. ໂທຫາ **1-888-587-8088 (TTY: 1-800-735-2929)**.

FACSIMILE TRANSMITTAL

Date: «Current_Date»	
To: «Prescriber_Name_First_Name_Last_Name»	**From:** Pharmacy Management Department
Prescriber Fax: «Prescriber_Fax»	**Phone:** (888) 807-5705
Pharmacy Fax: «Rx_Fax»	**Fax:** (714) 954-2280
Subject: «Appeal_Type» Pharmacy Appeal Request	

CONFIDENTIAL: If you receive this fax in error please call CalOptima immediately at (888) 807-5705.

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«Prescriber_Name_First_Name_Last_Name»
«Prescriber_Address»
«Prescriber_City», «Prescriber_State» «Presciber_Zip_Code»

Reference #: «Appeal_ID»
«Current_Date»
Provider: Dr. «Prescriber_Name_First_Name_Last_Name»
Member Name: «Mbr_Name_First_Name_Last_Name»
Member ID#: «Mbr_ID»

RE: «Drug_Name», «Qty» per «Days_Supply» days

CalOptima is issuing a Notice of Appeal Resolution letter regarding a recent request that was submitted.

Attached is a copy of the “Notice of Appeal Resolution” letter sent to a CalOptima member under your care.

Thank you,

«RPh_Decision_Maker_Overturn_Only»
Clinical Pharmacist
Pharmacy Management Department
Phone number: (714) 246-8471

"Overturn"

Appeal ID: «Appeal_ID»

NOTICE OF APPEAL RESOLUTION

«Current_Date»

«Mbr_Name_First_Name_Last_Name»
«Address»
«City», «State» «Zip_Code»

«Prescriber_Name_First_Name_Last_Name»
«Prescriber_Address»
«Prescriber_City», «Prescriber_State»
«Presciber_Zip_Code»

Member Identification Number: «Mbr_ID»

RE: «Drug_Name», «Qty» for «Days_Supply» days

You or «Prescriber_Name_First_Name_Last_Name», on your behalf, appealed the «Previous_PA_Status» of «Drug_Name», «Qty» for «Days_Supply» days. CalOptima has reviewed the appeal and has decided to overturn the original decision. This request was reviewed by a clinical pharmacist and is now approved. This is because «Rationale_overturn_upheld»

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 **1-888-587-8088.**

This notice does not affect any of your other Medi-Cal services.

CalOptima Pharmacy Management

NONDISCRIMINATION NOTICE

Discrimination is against the law. CalOptima follows Federal civil rights laws. CalOptima does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

CalOptima provides:

- Free aids and services to people with disabilities to help them communicate better, such as:

  ✓ Qualified sign language interpreters
  ✓ Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose primary language is not English, such as:

  ✓ Qualified interpreters
  ✓ Information written in other languages

If you need these services, contact CalOptima between 8 a.m. - 5:30 p.m. by calling **1-888-587-8088**. Or, if you cannot hear or speak well, please call **TTY/TDD 1-800-735-2929**.

HOW TO FILE A GRIEVANCE

If you believe that CalOptima has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with CalOptima. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact CalOptima between 8 a.m. - 5:30 p.m. by calling **1-888-587-8088**. Or, if you cannot hear or speak well, please call **TTY/TDD 1-800-735-2929**.

- In writing: Fill out a complaint form or write a letter and send it to:

  CalOptima
  505 City Parkway West
  Orange, CA 92868

- In person: Visit your doctor's office or CalOptima and say you want to file a grievance.

- Electronically: Visit CalOptima's website at www.CalOptima.org.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call **1-888-587-8088 (TTY: 1-800-735-2929)**.

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-888-587-8088 (TTY: 1-800-735-2929)**.

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-888-587-8088 (TTY: 1-800-735-2929).**

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung ikaw ay nagsasalita sa wikang Tagalog, may mga serbisyo sa pananalita na makakatulong sa iyo na maari mong gamitin nang walang bayad. Tumawag sa **1-888-587-8088 (TTY: 1-800-735-2929)**.

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-888-587-8088 (TTY: 1-800-735-2929)**번으로 전화해 주십시오.

繁體中文 (Chinese)
注意：如果您说繁體中文，您可以免費獲得語言援助服務。請致電 **1-888-587-8088（TTY：1-800-735-2929）**。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-888-587-8088 (TTY (հեռատիպ)՝ 1-800-735-2929)**:

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-888-587-8088 (телетайп: 1-800-735-2929)**.

فارسی (Farsi)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
با شماره **1-888-587-8088 (TTY: 1-800-735-2929)** تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-888-587-8088（TTY: 1-800-735-2929）まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEBTOOM: Yog tias koj hais lus Hmoob, muaj cov kev pab txhais lus, pab dawb rau koj. Hu rau **1-888-587-8088 (TTY: 1-800-735-2929)**.

ਪੰਜਾਬੀ (Punjabi)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।

1-888-587-8088 (TTY: 1-800-735-2929) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على رقم **1-888-587-8088 (TTY: 1-800-735-2929).**

हिंदी (Hindi)
ध्यान दें : यदि आप हिन्दी बोलते हैं, तो आपके लिए नि:शुल्क भाषा सहायता सेवाएं उपलब्ध हैं।
1-888-587-8088 (TTY: 1-800-735-2929) पर कॉल करें।

ภาษาไทย (Thai)
ข้อควรคำนึง: ถ้าหากคุณพูดภาษาไทย, คุณสามารถใช้บริการความช่วยเหลือทางภาษา, โดยไม่เสียค่าใช้จ่ายใด ๆ ได้โดย, โทร
1-888-587-8088 (TTY: 1-800-735-2929).

ខ្មែរ (Cambodian)
ចំណុចសំខាន់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
សេវាជំនួយផ្នែកភាសាគឺមានផ្តល់ជូនលោកអ្នកដោយឥតគិតថ្លៃ។ សូមទូរស័ព្ទទៅកាន់លេខ
1-888-587-8088 (TTY: 1-800-735-2929)។

ພາສາລາວ (Lao)
ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ,
ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໄດ້. ໂທຫາ **1-888-587-8088 (TTY: 1-800-735-2929)**.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB No.0938-0950

Appointment of Representative

Name of Party	Medicare Number (beneficiary as party) or National Provider Identifier (provider or supplier as party)

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____, to act as my representative in connection with my claim or asserted right under Title XVIII of the Social Security Act (the Act) and related provisions of Title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my claim, appeal, grievance or request wholly in my stead. I understand that personal medical information related to my request 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
Email Address (optional)		

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 (HHS); 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
Email Address (optional)		

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 HHS.

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 HHS

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 HHS (i.e., an Administrative Law Judge (ALJ) hearing or attorney adjudicator review by the Office of Medicare Hearings and Appeals (OMHA), Medicare Appeals Council review, or a proceeding before OMHA 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, OMHA review, 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 HHS 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, OMHA 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 HHS.

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 or complaint if you are filing a grievance or complaint, or an initial determination or decision if you are requesting an initial determination or decision. If additional help is needed, contact 1-800-MEDICARE (1-800-633-4227) or your Medicare plan. TTY users please call 1-877-486-2048.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you believe you've been discriminated against. Visit https://www.cms.gov/about-cms/agency-Information/aboutwebsite/cmsnondiscriminationnotice.html, or call 1-800-MEDICARE (1-800-633-4227) for more information.

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA): Practitioner and Member***
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1,2].	- **Practitioner:** Within 24 hours of receipt of the ~~decision[2]~~ request[2] (electronic and written notification) - **Member:** Within 2 business days of the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 5 working days of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Plan may extend the standard preservice time frame due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The Member or the Member's provider may request for an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest[2,3~~3~~,~~6~~]. ▪ The Delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner:** Within 24 hours of the decision[2], not to exceed 14 calendar days from the receipt of the request[2,3~~3~~] (electronic and written notification) - **Member:** Within 2 business days of making the decision[2], not to exceed 14 calendar days from the receipt of the request[2,3~~3~~] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.
Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or ~~Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or~~ • • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within24 hours of receipt of the ~~decision[2]~~ request[2] ~~,[3]~~ (electronic and written notification) - **Member:** Within 24 hours of the decision[2] ~~,[4]~~ (written notification)

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA) Notification: Practitioner and Member**
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member, the member's representative, or provider for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.[3] - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment; or • ~~Could seriously jeopardize the life, health or safety of the member or others, due to the member's psychological state, or~~ • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 24 hours of the decision[2] but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2,3]~~3~~ (electronic and written notification) - **Member:** Within 2 business days of the decision[2] but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2,3]~~3~~ (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to NCQA Timeliness of UM decision~~,~~[3]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of making the decision[2,3] (electronic and written notification) - **Member:** Within 24 hours of making the decision[2,3] (written notification)
Post-Services / Retrospective Review	▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within 24 hours of making the decision~~.~~[3] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] (written notification) - **Member:** Within 2 business days of the decision[3] but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] [3](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

Appeals Time period to file an appeal: within 60 days of the initial denial decision[5,6]		**Notice of Appeal Resolution (NAR) Notification Timeframe**
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request[5,6].	- **Practitioner:** Within 30 calendar days from the receipt of the request [5] (electronic & written notification) - **Member:** Within 30 of receipt of the request[5] -(written notification)

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	~~-~~ A decision to approve, modify, or deny is required within 72 hours of receiving the additional information, or as soon as a Member's health condition requires, after receipt of the request[5,6]. ~~- The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions:~~ ~~▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member or the member's representative for the specific information necessary to make the decision.~~ ~~▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information.~~ ~~▪ The extension period, within which a decision must be made by the Plan, begins:~~ ~~• On the date when the Plan receives the member's response (even if not all of the information is provided), or~~ ~~• At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative[5].~~ ~~-~~ - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or~~,~~ health ~~or safety~~ of the member or ~~others~~the member's ability to regain maximum function, based on a prudent layperson's judgment, ~~due to the member's psychological state,~~ or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours of the decision (electronic & written notification)[5,6] - **Member:** Within 72 hours of the decision (oral and written notification)[5]

~~Attachment B (for GG.1401 and GG.1410):~~

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Postservice Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request [5,6~~5~~].	- **Practitioner:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,~~5~~] (electronic & written notification) - **Member:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,~~5~~] (written notification).

*Decisions to approve, modify, or deny are communicated to the requesting provider; decisions resulting in denial, delay, or modification are communicated to the member.

References:

1. Welfare and Institutions Code section 14185(a)(1)
~~1.~~2. County Organized Health Systems Coordinated Care Initiative Boilerplate Contract
2. ~~California Health and Safety Code Sections (HSC) 1367.01(h)~~
~~4.~~3. UM 5: Timeliness of UM decisions, Element ~~CE~~: Notification of Pharmacy Decisions, 20~~18~~2018 HP Accreditation UM Standards.
~~5.~~4. UM 5: Timeliness of UM decisions, Element ~~DE~~: UM Timeliness ~~Report of Pharmacy UM Decisions~~, 20~~18~~2018 HP Accreditation UM Standards.
~~6.~~5. UM 9: Timeliness of the Appeal Process, Element ~~BE~~: Factor 1 to 3, 2020 HP Accreditation UM Standards. ~~.~~
~~7.~~ All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
6.

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA): Practitioner and Member***
Standard (Non-urgent) Preservice - All necessary information received at time of initial request	A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1,2].	- **Practitioner:** Within 24 hours of receipt of the request[2] (electronic and written notification) - **Member:** Within 2 business days of the decision[2] (written notification)
Standard (Non-urgent) Preservice - Extension Needed - Additional clinical information required - Requires consultation by an Expert Reviewer - Additional examination or tests to be performed - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 5 working days of receiving the additional information but no longer than 14 calendar days, upon receipt of the information reasonably necessary to render a decision. - The Plan may extend the standard preservice time frame due to a lack of information, for an additional 14 calendar days, under the following conditions: ▪ The Member or the Member's provider may request for an extension, or the Plan can provide justification upon request by the State for the need for additional information and how it is in the Member's interest[2,3,]. ▪ The Delay notice shall include the additional information needed to render the decision, the type of expert needed to review and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner:** Within 24 hours of the decision, not to exceed 14 calendar days from the receipt of the request[2,3] (electronic and written notification) - **Member:** Within 2 business days of making the decision, not to exceed 14 calendar days from the receipt of the request[2,3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.
Expedited (Urgent) Pre-Service - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function. - All necessary information received at time of initial request	- A decision to approve, modify, or deny is required within 24 hours for all drugs that require prior authorization in accordance with Welfare and Institutions Code Section 14185(a)(1)[1]. - **Expedited (Urgent) Pre-Service** may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[4].	- **Practitioner:** Within24 hours of receipt of the request[2] (electronic and written notification) - **Member:** Within 24 hours of the decision[2] (written notification)

Pharmacy Prior Authorization and Appeals: Timeframes for Decisions and Notifications for Pharmaceuticals Under the Pharmacy Benefit

Prior Authorization		Notification Timeframe
Type of Request	**Decision**	**Notice of Action (NOA) Notification: Practitioner and Member**
Expedited (Urgent) Pre-Service - Extension Needed - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4]. - Additional clinical information required - [AKA: Deferral or Request for Information (RFI)]	- A response to defer is required within 24 hours for all drugs that require prior authorization, in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours of initial receipt of the request[2,4]. - The Plan may extend the urgent preservice time frame due to a lack of information, once, for 48 hours, under the following conditions: ▪ Within 24 hours of receipt of the urgent preservice request, the Plan asks the member, the member's representative, or provider for the specific information necessary to make the decision. ▪ The Plan gives the member or member's authorized representative at least 48 hours to provide the information. ▪ The extension period, within which a decision must be made by the Plan, begins: • On the date when the Plan receives the member's response (even if not all of the information is provided), ***or*** • At the end of the time period given to the member to provide the information, if no response is received from the member or the member's authorized representative.[3] - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4]. - The Member or the Member's provider may request for an extension, or the Health Plan/ Provider Group can provide justification upon request by the State for the need for additional information and how it is in the Member's interest. - Notice of deferral should include the additional information needed to render the decision, the type of expert reviewed and/or the additional examinations or tests required and the anticipated date on which a decision will be rendered. - Any decision delayed beyond the time limits is considered a denial and must be immediately processed as such[2].	- **Practitioner and Member:** Within 24 hours of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2,3] (electronic and written notification) - **Member:** Within 2 business days of the decision but no later than 72 hours from receipt of information that is reasonably necessary to make a determination[2,3] (written notification) - **Note:** CalOptima shall make reasonable efforts to give the Member and Prescribing Provider oral notice of the delay.

Concurrent review of treatment regimen already in place - A request for coverage of pharmaceutical services made while a member is in the process of receiving the requested pharmaceutical services, even if the organization did not previously approve the earlier care.	- A response to defer is required within 24 hours for all drugs that require prior authorization in accordance to Welfare and Institutions Code Section 14185(a)(1)[1]. - A decision to approve, modify, or deny is required within 72 hours, or as soon as a Member's health condition requires, after the receipt of the request, in accordance to NCQA Timeliness of UM decision[3]. - If the plan is unable to request for an extension of an urgent concurrent care within 24 hours **before the expiration of the prescribed period of time or number of treatments**, then the organization may treat the request as urgent preservice and make a decision within 72 hours[2]. - The plan must document that it made at least one attempt to obtain the necessary information within 24 hours of the request but was unable to obtain the information. The plan has up to 72 hours to make a decision of approve, modify, or deny[2].	- **Practitioner:** Within 24 hours of making the decision[2,3] (electronic and written notification) - **Member:** Within 24 hours of making the decision[2,3] (written notification)
Post-Services / Retrospective Review	▪ A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request[2,4].	- **Practitioner:** Within 24 hours of making the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] (written notification) - **Member:** Within 2 business days of the decision but no later than 30 calendar days from receipt of information that is reasonably necessary to make a determination[2,3] [3](written notification)

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[5,6]		Notice of Appeal Resolution (NAR) Notification Timeframe
Type of Request	**Decision**	**Practitioner and Member**
Routine (Standard) Preservice Appeal	A decision to approve, modify, or deny is required within 30 calendar days of the initial receipt of the request[5,6].	- **Practitioner:** Within 30 calendar days from the receipt of the request [5] (electronic & written notification) - **Member:** Within 30 of receipt of the request[5] (written notification)
Expedited (Urgent) Pre-Service Appeal - Requests where the provider indicates or the Health Plan determines that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function[2,4].	- A decision to approve, modify, or deny is required within 72 hours of receiving the additional information, or as soon as a Member's health condition requires, after receipt of the request[5,6]. - **Expedited (Urgent) Pre-Service** request may be reclassified as **Standard (Non-urgent) Preservice** if the following definition for urgent request is not met: ▪ A request for pharmaceutical services where application of the time frame for making routine or non-life threatening care determinations: • Could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, based on a prudent layperson's judgment, or • In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment that is the subject of the request[2,4].	- **Practitioner:** Within 72 hours of the decision (electronic & written notification)[5,6] - **Member:** Within 72 hours of the decision (oral and written notification)[5]
Postservice Appeal	A decision to approve, modify, or deny is required within 30 days of the initial receipt of the request [5,6].	- **Practitioner:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,5] (electronic & written notification) - **Member:** Within 30 calendar days of the receipt of information that is reasonably necessary to make this determination[2,5] (written notification).

*Decisions to approve, modify, or deny are communicated to the requesting provider; decisions resulting in denial, delay, or modification are communicated to the member.

References:

1. Welfare and Institutions Code section 14185(a)(1)
2. County Organized Health Systems Coordinated Care Initiative Boilerplate Contract
3. UM 5: Timeliness of UM decisions, Element C: Notification of Pharmacy Decisions, 2020 HP Accreditation UM Standards.
4. UM 5: Timeliness of UM decisions, Element D: UM Timeliness Report, 2020 HP Accreditation UM Standards.
5. UM 9: Timeliness of the Appeal Process, Element B: Factor 1 to 3, 2020 HP Accreditation UM Standards.
6. All Plan Letter 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

Policy:	GG.1423
Title:	**Medication Quality Assurance Program**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	~~*Michael Schrader*~~ _____
Effective Date:	06/07/2011
Revised Date:	~~12/05/2019~~TBD

I. PURPOSE

This policy establishes a quality assurance program to reduce medication errors and adverse drug interactions, and improve medication use through prospective and retrospective drug utilization review (DUR).

II. POLICY

A. CalOptima shall ensure that Participating Pharmacies comply with the minimum standards for pharmacy practice as established by California in accordance with the California Business and Professions Code, Section 4000 *et. seq*.

B. CalOptima or its Pharmacy Benefit Manager (PBM) shall maintain quality assurance measures and systems including:

1. Prospective drug utilization review (DUR) systems;

2. Retrospective drug utilization review (DUR) systems; and

3. Internal medication error identification and reduction systems.

C. CalOptima shall provide information to the Department of Health Care Services (DHCS) regarding its quality assurance measures and systems pertaining to improving medication use, reducing medication errors, and adverse drug interactions.

D. CalOptima shall provide Members access to view their drug profile and to perform drug formulary validation in accordance with CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.

E. CalOptima shall perform medication reconciliation in accordance with CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

F. CalOptima shall establish systems and measures to ensure that Participating Pharmacies comply with CalOptima's quality assurance requirements by monitoring pharmacy claims data as described in Sections III.B.-D. of this Policy.

G. The PBM shall ensure that Participating Pharmacies offer patient counseling to Members, when appropriate, in accordance with state law.

H. Electronic Prescription Drug Program

Back to Agenda Back to Item

1. The PBM shall support electronic prescribing in accordance with applicable federal and state laws, regulations and standards, including, without limitations, Subpart D of 42 CFR Part 423.

2. The PBM shall establish and maintain an electronic prescription drug program that complies with applicable standards, including, without limitations, 42 CFR § 423.160(b), when transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media for Members.

3. The PBM shall ensure that all necessary contracts and systems are in place should prescribing health care practitioners desire to electronically transmit prescriptions for Members. The PBM shall ensure that Participating Pharmacies:

   a. Can receive electronic prescriptions (with allowance for exceptions when it is impractical or otherwise could jeopardize beneficiary access) in accordance with applicable standards. The PBM shall have an approval process for such exceptions and a process to redirect prescribing health care practitioners to appropriate alternate Participating Pharmacies.

   b. Process electronic prescriptions received from prescribing health care practitioners, when appropriate, in accordance with all applicable federal and state laws, regulations, and standards.

   c. Immediately notify the prescribing health care practitioner when the Participating Pharmacy, or its staff, is aware that an attempted transmission of an electronic prescription failed, is incomplete, or otherwise not properly received.

I. Participating Pharmacies shall implement a method to keep Member information records and maintain up-to-date Member information including, but not limited to:

   1. Member demographic information; and

   2. Member allergy information including drug and food allergies.

J. CalOptima shall make efforts toward including the following in quality assurance systems:

   1. Electronic prescribing;

   2. Clinical decision support systems;

   3. Educational interventions;

   4. Adverse event reporting systems; and

   5. Provider and Member education.

K. Effective July 1, 2017, CalOptima shall participate in a global Medi-Cal DUR program. The global Medi-Cal DUR program will assess data on drug use against predetermined standards, consistent with the following:

   1. Compendia, which shall consist of the following:

a. American Hospital Formulary Service Drug Information;

b. United States Pharmacopeia-Drug Information (or its successor publications);

c. The DrugDex Information System; and

2. Peer-reviewed medical literature.

L. CalOptima shall include the participation with the Medi-Cal DUR Board as part of its DUR Program activities.

1. CalOptima shall actively participate directly in the Medi-Cal DUR Board by means of the California Association of Health Plans.

2. On a quarterly basis, CalOptima shall assess the Medi-Cal DUR Board's recommendations and decide if it will adopt their recommendations or not. If CalOptima chooses not to adopt certain recommendations, a justification shall be provided to DHCS as part of the annual DUR report outlined in Section II.N of this policy.

M. CalOptima shall provide educational efforts and outreach programs, in collaboration with the Medi-Cal DUR Board, to improve the ability of physicians and pharmacists to identify patterns, and reduce the frequency, of fraud, abuse, misuse, and clinically inappropriate or medically unnecessary care. In addition to these educational outreach programs, CalOptima shall also distribute additional educational materials or articles based on the demographics and trends specific to Member and provider populations.

N. CalOptima shall submit a ~~detail~~detailed DUR report to DHCS, in a format specified by DHCS, on its DUR Program activities by April 1 of each year. The report shall include information related to the methodology by which CalOptima meets the requirements for the prospective and retrospective DUR. In addition, CalOptima shall also provide in its annual DUR report any educational programs provided outside of the global educational activities, the rationale for not implementing DUR Board recommended actions, and any other DUR related activities performed outside of the global DUR activities, as applicable.

O. Effective October 1, 2019, CalOptima shall operate a DUR program that complies with applicable statutory and regulatory requirements, including section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS. The following described safety edits and claims review requirements do not apply to Members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; Members who are receiving opioid agonist medications for treatment of substance use disorder; or other individuals the state elects to treat as exempted from such requirements.

1. Early refills of opioid-containing medications shall not be allowed until at least ninety percent (90%) of the time expected to be covered by the previous fill has passed;

2. Duplicate fills of opioid-containing medications shall not be allowed on the same date of service;

3. Acute opioid-containing medications shall not be allowed in excess of a 30-day supply without prior authorization; and

4. Chronic opioid-containing medication shall not be allowed in excess of a 60-day supply without prior authorization.

5. Pharmacy claims for Opioid-containing medications for Members enrolled for the treatment of chronic pain shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/daily per day without prior authorization.

III. PROCEDURE

A. A Participating Pharmacy shall conduct prospective DUR to ensure review of the prescribed drug therapy prior to dispensing or delivering a prescription to a Member. The prospective drug utilization review shall include, but not be limited to:

1. Screening for potential drug therapy problems due to therapeutic duplication;

2. Ingredient duplication;

3. Age and gender-related drug utilization;

4. Drug-to-drug interactions, including serious interactions with non-prescription or over-the-counter drugs;

5. Incorrect drug dosage, such as low or high dose, or duration of drug therapy;

6. Drug-disease contraindications;

7. Drug pregnancy precautions;

8. Drug-allergy contraindications; and

9. Clinical abuse or misuse.

B. CalOptima shall conduct retrospective DUR on a monthly basis to ensure ongoing examination of claims data and other records through computerized drug claims processing and information retrieval systems to:

1. Identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among Prescribing Providers, Participating Pharmacies, and Members; ~~and~~

2. Identify fraud and abuse patterns associated with specific drugs or groups of drugs; and

~~2.~~3. Report suspected fraud and abuse to CalOptima's Compliance Department in accordance with CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection.

C. The Pharmacy Management Department shall conduct retrospective DUR using the following methods which include, but are not limited to:

1. Claims oversight for the following:

    a. Claims for Medi-Cal FFS carve out medications;

    b. Claims for Medicare Part D-covered drugs for dual-eligible members;

    c. Over the counter drugs processed for members in Long-Term-Care Facilities;

    d. Acetaminophen products for adults over twenty-one (21) years of age;

    e. Over the counter cough and cold products for adults over twenty-one (21) years of age;

    f. Claims payment for members who are deceased;

    g. Members with paid claims from out of state pharmacies;

    h. Claims with ~~member~~Member copayments;

    i. Compounding claims with incorrect level of effort codes;

    j. Claims with incorrect dispensing fees; ~~and~~

    k. Claims with incorrect quantities;

    l. Duplicate fills for opioid medications;

    m. Early refills for opioid medications; and

    ~~k.~~n. Exceeding opioid quantity limits.

2. Members with potential over-utilization of pharmaceuticals as identified through:

    a. The Polypharmacy Management Program;

    b. The Pharmacy Home Program; and

    c. The Prescriber Restriction Program.

3. Identify Members with potential over-utilization of controlled substances.

4. Members with potential under-utilization of pharmaceuticals as identified through the following reports:

    a. Members with diabetes and not receiving a statin;

    b. Members with cardiovascular disease not receiving a statin; and

    c. Members hospitalized for an acute myocardial infarction not receiving persistent beta-blocker treatment for six (6) months after discharge.

5. For Members identified with over- or under-utilization of pharmaceuticals, CalOptima Pharmacy Management Department shall outreach to the Member's Primary Care Physician

(PCP) with recommendations to either remove or add additional therapy to the Member's drug regimen. The result of this outreach shall be tracked and reported quarterly at the Pharmacy and Therapeutics (P&T) Committee Meetings.

6. Other programs relating to the Health Effectiveness Data and Information Set (HEDIS).

7. Notwithstanding the above, CalOptima shall conduct retrospective claims reviews and regular care management activities, as applicable, for Members:

   a. Prescribed treatment in excess of the maximum MME/daily dose limitation;

   b. Concurrently prescribed opioids and benzodiazepines; and

   c. Concurrently prescribed opioids and antipsychotics.

   d. CalOptima shall take action on issues of concern identified as a result of retrospective claims review, including contacting a Member's PCP or other prescriber, and/or referral to the CalOptima Quality Improvement Department in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

D. The Pharmacy Management Department shall refer all potential drug-related Quality of Care issues to the Quality Improvement Department for follow-up in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

E. CalOptima shall utilize the Food and Drug Administration (FDA) Medwatch form for reporting adverse events and shall educate Providers about the availability of the Medwatch form.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
C. CalOptima Policy GG.1413: Polypharmacy Management
D. CalOptima Policy GG.1416: Pharmacy Home Program
E. CalOptima Policy GG.1611: Potential Quality Issue Review Process
F. CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.
G. CalOptima Policy GG.1611: Potential Quality Issue Review Process
~~G.~~H. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
I. CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection
~~H.~~J. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-008: Requirement to Participate in the Medi-Cal Drug Utilization Review Program
~~I.~~K. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-012 (revised): Federal Drug Utilization Review Requirements Designed to Reduce Opioid related Fraud, Misuse and Abuse
~~J.~~M. Health Homes Program Guide
~~K.~~N. Business and Professions Code, §§ 688 and 4070-4072
~~L.~~O. Health and Safety Code §§ 11164-11164.5
~~M.~~P. Title 16, California Code of Regulations (C.C.R.), § 1717.4

~~N.~~Q. Title 21, Code of Federal Regulations (C.F.R.), § 1311.200
~~O.~~R. Title 42, Code of Federal Regulations (C.F.R.), Part 456, Subpart K
~~P.~~S. Title 42, Code of Federal Regulations (C.F.R.), §§ 423.159, 423.160, and 438.3(s)(4)-(5)
~~Q.~~T. Section 1927(g) of the Social Security Act (SSA)

VI. REGULATORY AGENCY APPROVAL(S)

~~A. 06/12/17: Department of Health Care Services~~
~~B. 08/09/16: Department of Health Care Services~~
~~C. 08/21/14: Department of Health Care Services~~

Date	Regulatory Agency
08/21/2014	Department of Health Care Services (DHCS)
08/09/2016	Department of Health Care Services (DHCS)
06/12/2017	Department of Health Care Services (DHCS)
05/05/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

~~A. 12/05/2019:Regular Meeting of the CalOptima Board of Directors~~

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/07/2011	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2012	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	05/01/2014	GG.1423	Medication Quality Assurance Program	Medi-Cal
Reviewed	10/01/2015	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	06/01/2016	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	07/01/2017	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2018	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	12/05/2019	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	TBD	GG.1423	Medication Quality Assurance Program	Medi-Cal

IX. GLOSSARY

Term	Definition
Frequently Abused Drugs	A controlled substance under the Federal Controlled Substances Act that the Secretary determines is frequently abused or diverted, taking into account all of the following factors: (1) The drug's schedule designation by the Drug Enforcement Administration; (2) Government or professional guidelines that address that a drug is frequently abused or misused. (3) An analysis of Medicare or other drug utilization or scientific data. These drugs are determined by CMS annually.
Healthcare Effectiveness Data and Information Set (HEDIS™)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
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.
Pharmacy Home Program	A program by which a Member selects or is assigned to single provider of pharmaceutical services.
Polypharmacy	The simultaneous use of multiple medications by a single Member, for one (1) or more conditions.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
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 Medical Practitioner (NMP) (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	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.

Policy:	GG.1423
Title:	**Medication Quality Assurance Program**
Department:	Medical Management
Section:	Pharmacy Management
CEO Approval:	
Effective Date:	06/07/2011
Revised Date:	TBD

I. PURPOSE

This policy establishes a quality assurance program to reduce medication errors and adverse drug interactions, and improve medication use through prospective and retrospective drug utilization review (DUR).

II. POLICY

A. CalOptima shall ensure that Participating Pharmacies comply with the minimum standards for pharmacy practice as established by California in accordance with the California Business and Professions Code, Section 4000 *et. seq*.

B. CalOptima or its Pharmacy Benefit Manager (PBM) shall maintain quality assurance measures and systems including:

1. Prospective drug utilization review (DUR) systems;

2. Retrospective drug utilization review (DUR) systems; and

3. Internal medication error identification and reduction systems.

C. CalOptima shall provide information to the Department of Health Care Services (DHCS) regarding its quality assurance measures and systems pertaining to improving medication use, reducing medication errors, and adverse drug interactions.

D. CalOptima shall provide Members access to view their drug profile and to perform drug formulary validation in accordance with CalOptima Policy GG.1424: Pharmacy Benefit Information for Members.

E. CalOptima shall perform medication reconciliation in accordance with CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply.

F. CalOptima shall establish systems and measures to ensure that Participating Pharmacies comply with CalOptima's quality assurance requirements by monitoring pharmacy claims data as described in Sections III.B.-D. of this Policy.

G. The PBM shall ensure that Participating Pharmacies offer patient counseling to Members, when appropriate, in accordance with state law.

H. Electronic Prescription Drug Program

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1. The PBM shall support electronic prescribing in accordance with applicable federal and state laws, regulations and standards, including, without limitations, Subpart D of 42 CFR Part 423.

2. The PBM shall establish and maintain an electronic prescription drug program that complies with applicable standards, including, without limitations, 42 CFR § 423.160(b), when transmitting, directly or through an intermediary, prescriptions and prescription-related information using electronic media for Members.

3. The PBM shall ensure that all necessary contracts and systems are in place should prescribing health care practitioners desire to electronically transmit prescriptions for Members. The PBM shall ensure that Participating Pharmacies:

   a. Can receive electronic prescriptions (with allowance for exceptions when it is impractical or otherwise could jeopardize beneficiary access) in accordance with applicable standards. The PBM shall have an approval process for such exceptions and a process to redirect prescribing health care practitioners to appropriate alternate Participating Pharmacies.

   b. Process electronic prescriptions received from prescribing health care practitioners, when appropriate, in accordance with all applicable federal and state laws, regulations, and standards.

   c. Immediately notify the prescribing health care practitioner when the Participating Pharmacy, or its staff, is aware that an attempted transmission of an electronic prescription failed, is incomplete, or otherwise not properly received.

I. Participating Pharmacies shall implement a method to keep Member information records and maintain up-to-date Member information including, but not limited to:

   1. Member demographic information; and

   2. Member allergy information including drug and food allergies.

J. CalOptima shall make efforts toward including the following in quality assurance systems:

   1. Electronic prescribing;

   2. Clinical decision support systems;

   3. Educational interventions;

   4. Adverse event reporting systems; and

   5. Provider and Member education.

K. Effective July 1, 2017, CalOptima shall participate in a global Medi-Cal DUR program. The global Medi-Cal DUR program will assess data on drug use against predetermined standards, consistent with the following:

   1. Compendia, which shall consist of the following:

a. American Hospital Formulary Service Drug Information;

b. United States Pharmacopeia-Drug Information (or its successor publications);

c. The DrugDex Information System; and

2. Peer-reviewed medical literature.

L. CalOptima shall include the participation with the Medi-Cal DUR Board as part of its DUR Program activities.

1. CalOptima shall actively participate directly in the Medi-Cal DUR Board by means of the California Association of Health Plans.

2. On a quarterly basis, CalOptima shall assess the Medi-Cal DUR Board's recommendations and decide if it will adopt their recommendations or not. If CalOptima chooses not to adopt certain recommendations, a justification shall be provided to DHCS as part of the annual DUR report outlined in Section II.N of this policy.

M. CalOptima shall provide educational efforts and outreach programs, in collaboration with the Medi-Cal DUR Board, to improve the ability of physicians and pharmacists to identify patterns, and reduce the frequency, of fraud, abuse, misuse, and clinically inappropriate or medically unnecessary care. In addition to these educational outreach programs, CalOptima shall also distribute additional educational materials or articles based on the demographics and trends specific to Member and provider populations.

N. CalOptima shall submit a detailed DUR report to DHCS, in a format specified by DHCS, on its DUR Program activities by April 1 of each year. The report shall include information related to the methodology by which CalOptima meets the requirements for the prospective and retrospective DUR. In addition, CalOptima shall also provide in its annual DUR report any educational programs provided outside of the global educational activities, the rationale for not implementing DUR Board recommended actions, and any other DUR related activities performed outside of the global DUR activities, as applicable.

O. Effective October 1, 2019, CalOptima shall operate a DUR program that complies with applicable statutory and regulatory requirements, including section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, and applicable guidance issued by DHCS. The following described safety edits and claims review requirements do not apply to Members who are receiving hospice or palliative care; receiving treatment for cancer; residents of a long-term care facility, a facility described in section 1905(d) of the Act, or of another facility for which frequently abused drugs are dispensed for residents through a contact with a single pharmacy; Members who are receiving opioid agonist medications for treatment of substance use disorder; or other individuals the state elects to treat as exempted from such requirements.

1. Early refills of opioid-containing medications shall not be allowed until at least ninety percent (90%) of the time expected to be covered by the previous fill has passed;

2. Duplicate fills of opioid-containing medications shall not be allowed on the same date of service;

3. Acute opioid-containing medications shall not be allowed in excess of a 30-day supply without prior authorization; and

4. Chronic opioid-containing medication shall not be allowed in excess of a 60-day supply without prior authorization.

5. Pharmacy claims for Opioid-containing medications for Members enrolled for the treatment of chronic pain shall not exceed a cumulative morphine milligram equivalent (MME) of 500 MME/daily per day without prior authorization.

III. PROCEDURE

A. A Participating Pharmacy shall conduct prospective DUR to ensure review of the prescribed drug therapy prior to dispensing or delivering a prescription to a Member. The prospective drug utilization review shall include, but not be limited to:

1. Screening for potential drug therapy problems due to therapeutic duplication;

2. Ingredient duplication;

3. Age and gender-related drug utilization;

4. Drug-to-drug interactions, including serious interactions with non-prescription or over-the-counter drugs;

5. Incorrect drug dosage, such as low or high dose, or duration of drug therapy;

6. Drug-disease contraindications;

7. Drug pregnancy precautions;

8. Drug-allergy contraindications; and

9. Clinical abuse or misuse.

B. CalOptima shall conduct retrospective DUR on a monthly basis to ensure ongoing examination of claims data and other records through computerized drug claims processing and information retrieval systems to:

1. Identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among Prescribing Providers, Participating Pharmacies, and Members;

2. Identify fraud and abuse patterns associated with specific drugs or groups of drugs; and

3. Report suspected fraud and abuse to CalOptima's Compliance Department in accordance with CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection.

C. The Pharmacy Management Department shall conduct retrospective DUR using the following methods which include, but are not limited to:

1. Claims oversight for the following:

    a. Claims for Medi-Cal FFS carve out medications;

    b. Claims for Medicare Part D-covered drugs for dual-eligible members;

    c. Over the counter drugs processed for members in Long-Term-Care Facilities;

    d. Acetaminophen products for adults over twenty-one (21) years of age;

    e. Over the counter cough and cold products for adults over twenty-one (21) years of age;

    f. Claims payment for members who are deceased;

    g. Members with paid claims from out of state pharmacies;

    h. Claims with Member copayments;

    i. Compounding claims with incorrect level of effort codes;

    j. Claims with incorrect dispensing fees;

    k. Claims with incorrect quantities;

    l. Duplicate fills for opioid medications;

    m. Early refills for opioid medications; and

    n. Exceeding opioid quantity limits.

2. Members with potential over-utilization of pharmaceuticals as identified through:

    a. The Polypharmacy Management Program;

    b. The Pharmacy Home Program; and

    c. The Prescriber Restriction Program.

3. Identify Members with potential over-utilization of controlled substances.

4. Members with potential under-utilization of pharmaceuticals as identified through the following reports:

    a. Members with diabetes and not receiving a statin;

    b. Members with cardiovascular disease not receiving a statin; and

    c. Members hospitalized for an acute myocardial infarction not receiving persistent beta-blocker treatment for six (6) months after discharge.

5. For Members identified with over- or under-utilization of pharmaceuticals, CalOptima Pharmacy Management Department shall outreach to the Member's Primary Care Physician

(PCP) with recommendations to either remove or add additional therapy to the Member's drug regimen. The result of this outreach shall be tracked and reported quarterly at the Pharmacy and Therapeutics (P&T) Committee Meetings.

6. Other programs relating to the Health Effectiveness Data and Information Set (HEDIS).

7. Notwithstanding the above, CalOptima shall conduct retrospective claims reviews and regular care management activities, as applicable, for Members:

   a. Prescribed treatment in excess of the maximum MME/daily dose limitation;

   b. Concurrently prescribed opioids and benzodiazepines; and

   c. Concurrently prescribed opioids and antipsychotics.

   d. CalOptima shall take action on issues of concern identified as a result of retrospective claims review, including contacting a Member's PCP or other prescriber, and/or referral to the CalOptima Quality Improvement Department in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

D. The Pharmacy Management Department shall refer all potential drug-related Quality of Care issues to the Quality Improvement Department for follow-up in accordance with CalOptima Policy GG.1611: Potential Quality Issue Review Process.

E. CalOptima shall utilize the Food and Drug Administration (FDA) Medwatch form for reporting adverse events and shall educate Providers about the availability of the Medwatch form.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1408: Pharmacy Audits and Reviews
C. CalOptima Policy GG.1413: Polypharmacy Management
D. CalOptima Policy GG.1416: Pharmacy Home Program
E. CalOptima Policy GG.1611: Potential Quality Issue Review Process
F. CalOptima Policy GG.1424: Pharmacy Benefit Information for Members
G. CalOptima Policy GG.1611: Potential Quality Issue Review Process
H. CalOptima Policy GG.1639: Post-Hospital Discharge Medication Supply
I. CalOptima Policy HH.1105Δ: Fraud, Waste, and Abuse Detection
J. Department of Health Care Services (DHCS) All Plan Letter (APL) 17-008: Requirement to Participate in the Medi-Cal Drug Utilization Review Program
K. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-012: Health Homes Program Requirements
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-012 (revised): Federal Drug Utilization Review Requirements Designed to Reduce Opioid related Fraud, Misuse and Abuse
M. Health Homes Program Guide
N. Business and Professions Code, §§ 688 and 4070-4072
O. Health and Safety Code §§ 11164-11164.5
P. Title 16, California Code of Regulations (C.C.R.), § 1717.4

Q. Title 21, Code of Federal Regulations (C.F.R.), § 1311.200
R. Title 42, Code of Federal Regulations (C.F.R.), Part 456, Subpart K
S. Title 42, Code of Federal Regulations (C.F.R.), §§ 423.159, 423.160, and 438.3(s)(4)-(5)
T. Section 1927(g) of the Social Security Act (SSA)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
08/21/2014	Department of Health Care Services (DHCS)
08/09/2016	Department of Health Care Services (DHCS)
06/12/2017	Department of Health Care Services (DHCS)
05/05/2020	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
12/05/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	06/07/2011	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2012	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	05/01/2014	GG.1423	Medication Quality Assurance Program	Medi-Cal
Reviewed	10/01/2015	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	06/01/2016	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	07/01/2017	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	01/01/2018	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	12/05/2019	GG.1423	Medication Quality Assurance Program	Medi-Cal
Revised	TBD	GG.1423	Medication Quality Assurance Program	Medi-Cal

IX. GLOSSARY

Term	Definition
Frequently Abused Drugs	A controlled substance under the Federal Controlled Substances Act that the Secretary determines is frequently abused or diverted, taking into account all of the following factors: (1) The drug's schedule designation by the Drug Enforcement Administration; (2) Government or professional guidelines that address that a drug is frequently abused or misused. (3) An analysis of Medicare or other drug utilization or scientific data. These drugs are determined by CMS annually.
Healthcare Effectiveness Data and Information Set (HEDIS™)	The set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance (NCQA).
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.
Pharmacy Home Program	A program by which a Member selects or is assigned to single provider of pharmaceutical services.
Polypharmacy	The simultaneous use of multiple medications by a single Member, for one (1) or more conditions.
Prescribing Provider	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
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 Medical Practitioner (NMP) (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	All contracted Providers including physicians, Non-physician Medical Practitioners, ancillary providers, and facilities or institutions who furnish covered services.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Ratification of the Kaiser Foundation Health Plan, Inc. Health Network Contract Amendment

Contact

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

Recommended Actions

Ratify the amendment to the Kaiser Foundation Health Plan, Inc. (Kaiser) Health Network contract, extending the term through September 30, 2020.

Background/Discussion

Kaiser participates in the CalOptima Medi-Cal program as a delegated subcontractor under its Health Maintenance Organization ("HMO") Health Network model. Each of CalOptima's contracts with its 12 twelve Medi-Cal Health Networks, including Kaiser, include a provision permitting an annual one-year extension of the contract subject to CalOptima Board of Directors' approval and signed contract amendments. Kaiser's current Health Network Contract ("Kaiser Contract") expired June 30, 2020. Last year, CalOptima staff presented Kaiser with an Amended and Restated Contract which incorporated past amendments and added DHCS required contract terms, including those related to the Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001 addressing certain terms that are required to be included in order for CalOptima to release Proposition 56 funds and other directed payments. Kaiser has not, however, executed the Amended and Restated Contract. CalOptima and Kaiser have been working with DHCS over the last several months to obtain additional clarification on certain subcontractor requirements. The parties have also been reviewing certain contract provisions that memorialize operational requirements in light of Kaiser's unique staff model.

In order to allow time for Kaiser and CalOptima to obtain final clarification from DHCS and finalize discussions with Kaiser, the parties entered into a ninety (90) day extension of the Kaiser Contract through September 30, 2020, subject to Board approval. Additionally, because Kaiser is the only Health Network delegated to provide the pharmacy benefit, CalOptima and Kaiser also need to address contract terms related to the State of California's carve out of the pharmacy benefit from CalOptima's DHCS Medi-Cal contract. The pharmacy benefit carve-out will be effective January 1, 2021 for all Managed Care Plans, including CalOptima.

Staff recommends ratification of the Kaiser Contract amendment to provide additional time to obtain DHCS's final guidance, and for the parties to reach agreement on the Amended and Restated Contract terms.

Fiscal Impact

The recommended action to ratify the amendment to the Kaiser Contract to extend the term through September 30, 2020, under the same terms and conditions, has no additional fiscal impact to the CalOptima FY 2020-21 Operating Budget approved by the Board on June 4, 2020.

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Rationale for Recommendation

This extension will allow additional time to review and finalize Kaiser's FY 2020-21 Health Network contract.

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Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action Dated June 4, 2020; "Authorize Extension and Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts with Kaiser Permanente

/s/ Richard Sanchez *07/29/2020*

Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

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

5/29/2019 — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

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1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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 PLs. 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

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

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

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), 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 (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Rev. 6/7/2018

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

Implementation Plan Elements

Delivery Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Candidates for the open positions are as follows:
Family Representatives

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

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

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

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

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

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

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

~~*CBO/Advocate Representatives*~~

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

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

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

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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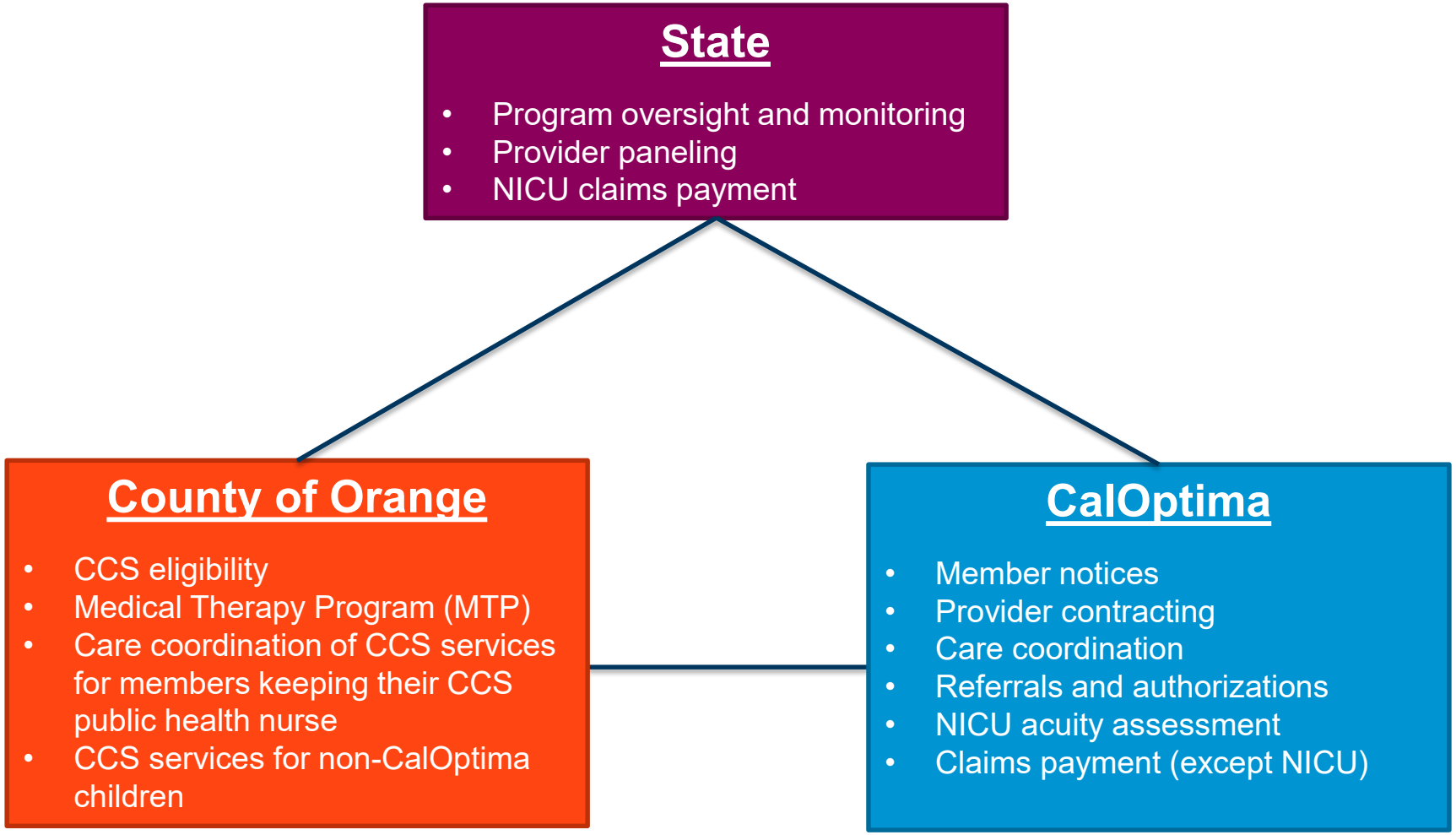
Background

Whole-Child Model (WCM) Overview

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

Division of WCM Responsibilities



WCM Transition Goals

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

CCS Demographics

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

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

WCM Requirements

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

2018 Stakeholder Engagement to Date

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

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Implementation Plan Elements

Proposed Delivery Model

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

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

Financial Approach

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

Clinical Operations

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

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

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

Provider Impact and Network Adequacy

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

Memorandum of Understanding (MOU)

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

WCM Family Advisory Committee

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

WCM Family Advisory Committee (cont.)

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

Recommended Nominees

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

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

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

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

Rev. 11/2/17

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

Background

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

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

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

    a. Community-based organizations; or

    b. Consumer advocates.

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

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

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

G. Stipends

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

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

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

I. WCM FAC Vacancies

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

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

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

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

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

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

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

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

1. The WCM FAC nomination ad hoc subcommittee shall:

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

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

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

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

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

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

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

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

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

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

B. WCM FAC recruitment process

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

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

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

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

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

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

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

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

C. WCM FAC nomination evaluation process

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

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

IX. GLOSSARY

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

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

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

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

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

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

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

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

_____

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

Member Name: _____ Relationship: _____

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

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

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

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

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

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

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

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

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

PUBLIC RECORDS ACT NOTICE

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

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

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

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

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

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

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

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

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

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

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

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

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

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

EXPIRATION DATE:

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

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

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

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

RESTRICTIONS:

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

MEMBER RIGHTS:

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

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

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

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

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

Applicant Name: _____

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

WCM FAC Seat: _____

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

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

_____
Name of Evaluator

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

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

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

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

☐ Community-based organizations

☐ Consumer advocates

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

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

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

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

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

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

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

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

Applications must be received by March 30, 2018.

Public Records Act Notice

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

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

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

WCM FAC Seat: _____

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

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

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

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

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), 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 (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

Back to Agenda Back to Item

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Rev. 6/7/2018

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

Implementation Plan Elements

Delivery Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Candidates for the open positions are as follows:
Family Representatives

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

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

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

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

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

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

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

~~*CBO/Advocate Representatives*~~

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

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

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

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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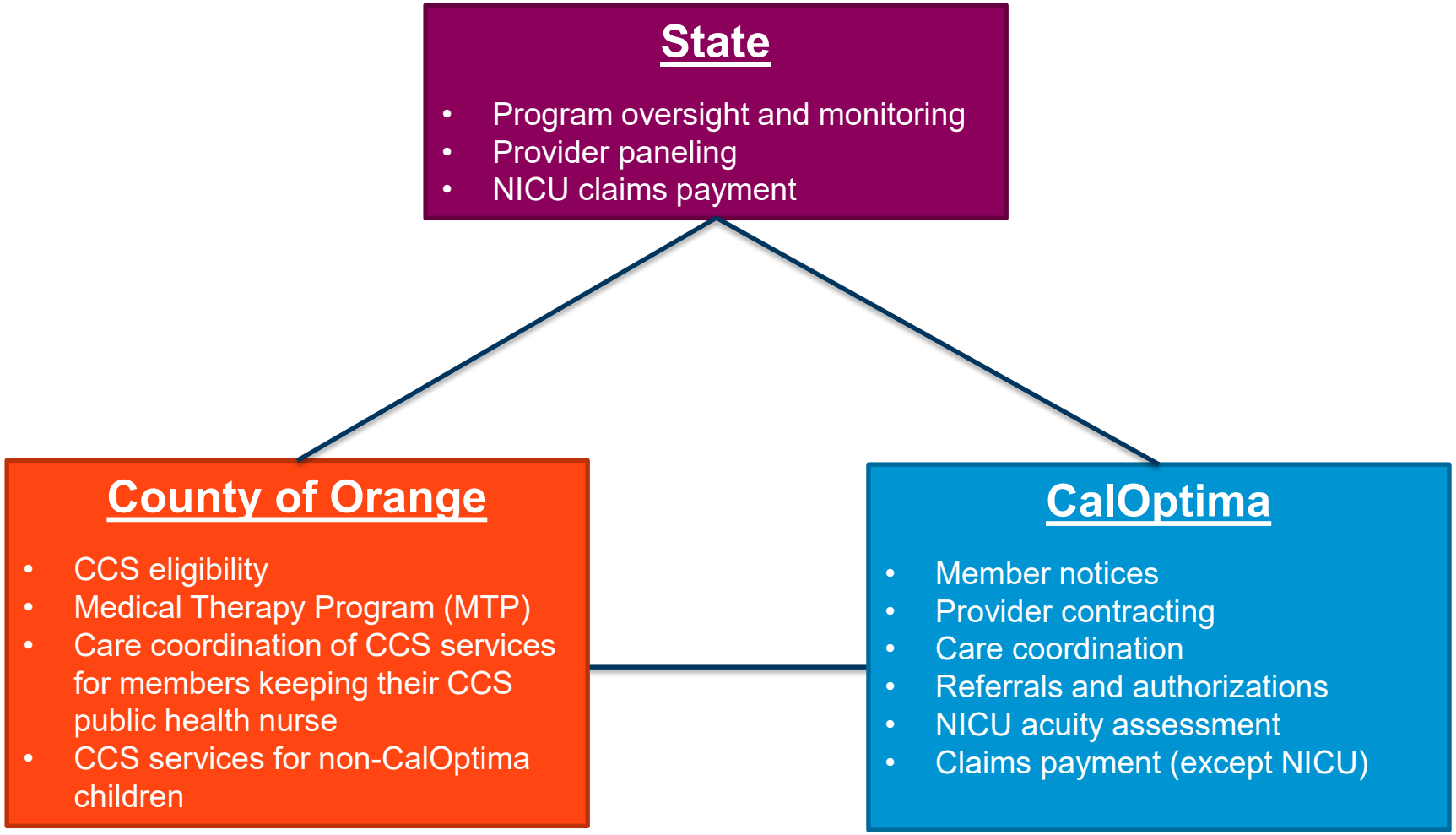
Background

Whole-Child Model (WCM) Overview

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

Division of WCM Responsibilities



WCM Transition Goals

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

CCS Demographics

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

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

WCM Requirements

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

2018 Stakeholder Engagement to Date

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

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Implementation Plan Elements

Proposed Delivery Model

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

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

Financial Approach

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

Clinical Operations

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

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

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

Provider Impact and Network Adequacy

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

Memorandum of Understanding (MOU)

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

WCM Family Advisory Committee

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

WCM Family Advisory Committee (cont.)

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

Recommended Nominees

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

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

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

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

Rev. 11/2/17

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

Background

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

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

Discussion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

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

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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

I. PURPOSE

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

II. POLICY

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

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

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

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

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

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

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

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

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

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

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

    a. Community-based organizations; or

    b. Consumer advocates.

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

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

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

G. Stipends

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

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

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

I. WCM FAC Vacancies

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

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

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

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

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

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

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

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

1. The WCM FAC nomination ad hoc subcommittee shall:

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

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

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

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

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

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

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

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

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

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

B. WCM FAC recruitment process

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

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

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

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

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

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

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

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

C. WCM FAC nomination evaluation process

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

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

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

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

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

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

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

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

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

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

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

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

IV. ATTACHMENTS

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

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

IX. GLOSSARY

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

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

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

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

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

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

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

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

_____

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

Member Name: _____ Relationship: _____

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

_____

_____

_____

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

_____

_____

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

_____

_____

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

_____

_____

_____

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

_____

_____

_____

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

_____

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

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

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

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

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

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

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

PUBLIC RECORDS ACT NOTICE

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

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

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

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

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

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

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

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

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

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

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

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

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

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

EXPIRATION DATE:

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

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

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

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

RESTRICTIONS:

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

MEMBER RIGHTS:

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

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

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

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

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

Applicant Name: _____

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

WCM FAC Seat: _____

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

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

_____
Name of Evaluator

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

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

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

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

☐ Community-based organizations

☐ Consumer advocates

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

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

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

_____

_____

_____

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

_____

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

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

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

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

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

Applications must be received by March 30, 2018.

Public Records Act Notice

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

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

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

WCM FAC Seat: _____

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

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

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact

The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

   a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

   b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

   a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

   a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

   b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose 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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.,* based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

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C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.,* between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

   c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.,* Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose 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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
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), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
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.
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.
Shared Risk Group (SRG)	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.

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.

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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 — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Contract Model Changes for Physician-Hospital Consortium Health Networks

Contact

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

Recommended Actions

1. Authorize currently participating Physician-Hospital Consortium (PHC) Health Networks to change their contract risk model for the Medi-Cal (MC) line of business to a Health Maintenance Organization (HMO) model, subject to successfully completing CalOptima's readiness assessment and obtaining Department of Managed Health Care (DMHC) licensure; and,
2. Authorize the termination of the Medi-Cal PHC health network current Physician and Hospital contracts to transition the capitated membership to the HMO health network model; and,
3. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute contracts and/or contract amendments necessary to implement the new HMO model for existing PHC Health Networks that elect to participate in CalOptima's Medi-Cal program under the HMO model.

Background/Discussion

CalOptima utilizes three different contract risk models for its Medi-Cal program, each entailing varying levels of financial risk: Physician Hospital Consortia (PHC), Shared-Risk Group (SRG), and Health Maintenance Organization (HMO). CalOptima currently contracts with three (3) PHC health networks, five (5) SRG Health Networks, and four (4) HMO Health Networks to administer its Medi-Cal program. Both the PHC and HMO models are full risk models. Under the PHC Health Network model, the Physician Group and Hospital in the PHC are separately contracted and are capitated only for the services delegated to them under their respective contracts. Under the HMO model, the HMO is a single entity that may accept risk for all delegated contracted covered services as a DMHC licensed HMO plan.

Staff is recommending the CalOptima Board of Directors consider authorizing the existing PHC Health Networks to convert their risk model to an HMO model if licensed as such by DMHC prospectively. This would allow CalOptima staff to work directly with the PHC Health Networks seeking to change the Medi-Cal contract risk arrangement to an HMO model including the initiation of the readiness assessment. Permission would be required to terminate the PHC network Physician and Hospital contracts as the capitated member enrollment of the PHC moves to an HMO contract model. The HMO could contract with the same PHC network Hospital or other hospitals for inpatient/outpatient hospital services.

If approved, this proposed recommendation would allow existing PHC Health Networks to participate in CalOptima's Medi-Cal program under the HMO contract risk model, provided they meet all regulatory and operational readiness requirements associated with the proposed contracting change. A PHC wishing to convert their contract risk model with CalOptima to HMO would be required to have or

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obtain a minimum Restricted Knox-Keene license, and meet all pre-contracting requirements inclusive of audits to be considered as a CalOptima HMO-contracted Health Network.

Changes to the risk model for Health Networks contracted to participate in the Cal MediConnect ("OneCare Connect") and CalOptima's Dual Eligible Special Needs Plans OneCare program are not addressed in this recommended action given the approaching sunset of the Cal MediConnect program by the Department of Health Care Services (DHCS) in 2022. That transition may require contract risk model changes to ensure consistency for the member's access to services. Additionally, risk model changes for SRG Health Networks contracted to participate in CalOptima's Medi-Cal program will need to be further evaluated to determine the impact to CalOptima as a whole and the complex financial considerations associated with the disruption of the shared risk pools maintained between CalOptima and the contracted SRG Health Networks before staff makes any additional recommendations regarding any other potential risk model transitions.

Fiscal Impact
The recommended action to allow existing PHC Health Networks to convert to an HMO risk model, subject to satisfactorily completing the readiness assessment and obtaining DMHC licensure has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2020-21 Operating Budget.

Rationale for Recommendation
Allowing existing PHC Health Networks to request changes to their Medi-Cal contract risk model from a PHC to HMO model will expand Member access and allow existing PHC Health Networks the flexibility to participate in the CalOptima Medi-Cal program in the preferred contract model which best meets their business needs.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Entities Covered by This Recommended Action

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network Inc	**600 City Parkway West, Ste. 800**	**Orange**	**CA**	**92868**
Children's Hospital of Orange County and CHOC Physicians Network	**1120 West La Veta Avenue Ste. 450**	**Orange**	**CA**	**92868**
Family Choice Medical Group	**7631 Wyoming St., Ste. 202**	**Westminster**	**CA**	**92683**
Fountain Valley Regional Hospital and Medical Center	**17100 Euclid St.**	**Fountain Valley**	**CA**	**92708**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Ratification of Data Sharing Agreement with Magellan Medicaid Administration, Inc.

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

Recommended Action
Ratify actions by the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a data sharing agreement with Magellan Medicaid Administration, Inc. (Magellan) to effectuate the transfer of Medi-Cal Pharmacy Benefit data, including those related to the Whole Child Model, to the State of California.

Background
On January 7, 2019, Governor Gavin Newsom signed Executive Order N-01-19 that will transition management of Medi-Cal pharmacy benefits from the Medi-Cal Managed Care Plans (MCPs), including CalOptima, to a Fee-for-Service Pharmacy Benefits Manager (PBM) directly contracted with the State of California (State). The State selected Magellan as its PBM through a competitive Request for Proposal process, with the contract awarded in December 2019. The transition is part of an effort to mitigate high prescription drug costs. Upon implementation, the state managed program—called Medi-Cal Rx—is designed to simultaneously provide cost savings and increased access through a wider, state-wide pharmacy network, as well as to standardize pharmacy benefits for all Medi-Cal beneficiaries, including those receiving services through California Children's Services, which is referred to as the Whole Child Model in Orange County.

Medi-Cal Rx is slated to go into effect on January 1, 2021, with approximately 11 million Medi-Cal beneficiaries to be moved over to the new carve out benefit statewide. The transition impacts all MCPs across the state, with the exception of the Program of All-Inclusive Care for the Elderly (PACE). Under the new structure, the State will assume the majority of management activities related to pharmacy benefits administration. MCPs will be responsible for activities including, but not limited to:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other DHCS-driven pharmacy committee meetings.

Discussion
Staff requests that the Board ratify the execution of Magellan's Data Sharing Agreement ("Magellan Agreement") to facilitate a seamless and efficient PBM transition.

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As of January 1, 2021, Medi-Cal Rx will take over the responsibility from MCPs for administering the following when billed by a pharmacy on a pharmacy claim: Covered Outpatient Drugs including Physician Administered Drugs, Medical Supplies, and Enteral Nutritional Products.

As part of the transition, which is currently in progress, DHCS is facilitating data transfer of pharmacy information between MCPs, including CalOptima, and Magellan, the State's new PBM. This data includes claims, prior authorization, and other necessary benefit utilization information. To obtain authorization for data transfer, Magellan distributed a Data Sharing Agreement to all MCPs on June 8, 2020, requiring signature by July 2, 2020. Based on confirmation from the DHCS that MCPs were required to sign the Magellan Agreement, CalOptima staff signed the document on July 2, 2020, accommodating Magellan's target effective date of July 15, 2020 when data sharing was set to begin.

To effectuate the transfer of pharmacy data as required by the Magellan Agreement, CalOptima was also required to sign a Data Authorization Request form with MedImpact, CalOptima's PBM, for CalOptima's members. Through this form, CalOptima consented to the release of CalOptima member pharmacy information to Magellan. For CalOptima members receiving care under CalOptima's full-service Kaiser HMO Health Network arrangement, pharmacy benefits are provided directly from Kaiser rather than through MedImpact. Therefore, Kaiser will separately provide members' pharmacy encounter and prescription data to Magellan. DHCS approved Kaiser's direct transfer of pharmacy encounter and prescription data to Magellan. Accordingly, CalOptima, approved Kaiser's request to share member pharmacy information directly with Magellan.

Fiscal Impact
The recommended action to ratify execution of the Magellan Agreement is budget neutral.

Rationale for Recommendation
Ratification of the Magellan Agreement and related implementing documents was approved by DHCS and is required in order for CalOptima to share pharmacy data with the Magellan, DHCS's selected pharmacy benefit manager.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Action
2. DHCS Publication_Pharmacy Services Transition

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E. Walnut St.	Pasadena	CA	91188
Magellan Medicaid Administration, Inc.	11013 W. Broad St., Suite 500	Glen Allen	VA	23060
MedImpact Healthcare Systems, Inc.	10181 Scripps Gateway Ct.	San Diego	CA	92131

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Medi-Cal Rx: Transitioning Medi-Cal Pharmacy Services from Managed Care to Fee-For-Service Frequently Asked Questions

The following Frequently Asked Questions document provides additional guidance and clarification to Medi-Cal beneficiaries, providers, plan partners, and other interested parties, regarding the January 2021 transition of Medi-Cal's pharmacy benefit (collectively referred to as "Medi-Cal Rx"). As the Department of Health Care Services (Department) receives additional questions, this document will be updated as indicated by the version number and date in the footer. Any new and/or revised questions or language will be denoted through the use of **bold** and underlined text, e.g., "**Sample**".

For information regarding Medi-Cal Rx, please visit the Department's dedicated Medi-Cal Rx: Transition website. In addition, general questions regarding Medi-Cal Rx may also be submitted to the Department via email at RxCarveOut@dhcs.ca.gov.

GENERAL INFORMATION

1. **Why is the Department transitioning the Medi-Cal pharmacy benefit from the Medi-Cal managed care delivery system to fee-for-service delivery system?**

   The Department is transitioning Medi-Cal pharmacy services from the Medi-Cal managed care delivery system to the Medi-Cal fee-for-service delivery system as a result of Governor Newsom's January 7, 2019 Executive Order N-01-19, for the purpose of achieving cost-savings for drug purchases made by the state, to standardize the pharmacy benefit statewide for all Medi-Cal beneficiaries and increase overall access by allowing beneficiaries to receive pharmacy services from the fee-for-service broader pharmacy network. In addition this standardization is a critical step for the success of the California Advancing and Innovating Medi-Cal (CalAIM) initiatives being proposed by the Department. For more information on CalAIM, please visit the Department's website.

2. **What is Medi-Cal Rx?**

   Medi-Cal Rx is the name the Department has given to this new system of how Medi-Cal pharmacy benefits will be administered through the fee-for-service delivery system, beginning on January 1, 2021.

3. **What are the advantages of transitioning Medi-Cal pharmacy benefits from managed care to fee-for-service?**

   Transitioning pharmacy services from Medi-Cal managed care to fee-for-service will, among other things:

   - Standardize the Medi-Cal pharmacy benefit statewide, under one delivery system.
   - Improve access to pharmacy services with a pharmacy network that includes the vast majority of the state's pharmacies and is generally more expansive than individual Medi-Cal Managed Care Plan pharmacy networks.
   - Apply statewide utilization management protocols to all outpatient drugs, as appropriate.

- Strengthen California's ability to negotiate state supplemental drug rebates with drug manufacturers as the largest Medicaid program in the state with approximately 13 million beneficiaries.

4. Does the Department need to seek federal approval to implement Medi-Cal Rx?

No, the Department does not need to seek federal approval from the Centers for Medicare and Medicaid services to implement Medi-Cal Rx. Since the Department is not changing the availability of the pharmacy benefit but rather is modifying which delivery system through which the benefit will be provided, no specific federal approval is required. Changes will be made administratively to Medi-Cal Managed Care Plan contracts.

5. What Medi-Cal Managed Care Plans are and are not impacted by Medi-Cal Rx?

All Medi-Cal Managed Care Plans, including Senior Care Action Network (SCAN) and AIDS Healthcare Foundation are impacted Medi-Cal Rx will not apply to Programs of All-Inclusive Care for the Elderly (PACE) plans **and Cal MediConnect health plans**.

6. Will Medi-Cal Rx apply to California Children's Services, and if yes, will Medi-Cal Rx change California Children's Services, and how does it intend to address California Children's Services-unique issues?

Medi-Cal Rx will apply to California Children's Services. The Department is still evaluating the potential impacts that Medi-Cal Rx may have on California Children's Services. As more information becomes available and policy approaches are further refined, the Department will reach out to engage members of the California Children's Services Advisory Workgroup for feedback and input to help inform Medi-Cal Rx implementation efforts.

7. What will not change as part of Medi-Cal Rx?

Medi-Cal Rx will not change the following:

- The scope of the existing Medi-Cal pharmacy benefit.
- Provision of pharmacy services in an inpatient or long-term care setting (including Skilled Nursing Facilities and other Intermediate Care Facilities, regardless of delivery system).
- Existing Medi-Cal managed care pharmacy carve-outs will continue (e.g., blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat substance use disorder).
- Any pharmacy services that are billed as a medical and/or institutional claim instead of a pharmacy claim.
- The State Fair Hearing process, as defined in applicable California state law.

8. What pharmacy benefits will be "carved out" of Medi-Cal managed care due to Medi-Cal Rx?

As of January 1, 2021, Medi-Cal Rx will take over the responsibility from Medi-Cal Managed Care Plans for administering the following **when billed by a pharmacy on a pharmacy claim**:

- Covered Outpatient Drugs, including Physician Administered Drugs (PADs)
- Medical Supplies
- Enteral Nutritional Products

9. Does Medi-Cal Rx include pharmacy benefits billed on medical and/or institutional claims?

No, as of January 1, 2021, Medi-Cal pharmacy services billed on a medical or institutional claim by a pharmacy, or any other provider, will continue to be billed, through either Medi-Cal Managed Care Plans or the Medi-Cal fee-for-service Fiscal Intermediary, as they have been prior to January 1, 2021. This also includes drugs currently "carved-out" of managed care delivery system (e.g., blood factor, HIV/AIDS drugs, antipsychotics, or drugs used to treat substance use disorder).

PROCUREMENT INFORMATION

10. How will the Department administer Medi-Cal Rx?

The Department has released Request for Proposal #19-96125 to procure an administrative services contractor to administer the Medi-Cal fee-for-service pharmacy services for over 13 million Medi-Cal beneficiaries. The Medi-Cal Rx Contractor will be responsible for providing a comprehensive suite of administrative services to the Department, which include but are not limited to, claims management, prior authorization and utilization management, pharmacy drug rebate administration, provider and beneficiary support services, and other ancillary and reporting services to support the administration of the Medi-Cal pharmacy benefit.

11. What is the Medi-Cal Rx procurement timeline?

Below is the timeline for Medi-Cal Rx procurement-related efforts.

- July 22, 2019: Draft Medi-Cal Rx Request for Proposal #19-96125 released for a two-week public comment period.
- August 22, 2019: Final Medi-Cal Rx Request for Proposal #19-96125 released.
- August 29, 2019: Final Medi-Cal Rx Request for Proposal #19-96125 questions due to the Department.
- September 17, 2019: Answers to questions related to the Final Medi-Cal Rx Request for Proposal #19-96125 and addenda posted.
- October 1, 2019: All Medi-Cal Rx Request for Proposal #19-96125 proposals due.
- **November 7, 2019: Notice of Intent to Award posted to the Department's website.**

- **December 13, 2019: The Department awarded contract to Magellan Medicaid Administration, Inc.**
- **December 20, 2019: Contract Effective Date**
- January 1, 2021: Medi-Cal Rx Assumption of Operations takes place.

12. Who is the Medi-Cal Rx Contractor selected through the procurement process?

The Medi-Cal Rx Contractor selected to administer Medi-Cal fee-for-service pharmacy services is Magellan Medicaid Administration, Inc.

13. What roles and responsibilities will Medi-Cal Managed Care Plans maintain as of January 1, 2021?

Medi-Cal Managed Care Plans will be responsible for activities including, but not limited to, the following:

- Overseeing and maintaining all activities necessary for enrolled Medi-Cal beneficiary care coordination and related activities, consistent with contractual obligations.
- Providing oversight and management of all the clinical aspects of pharmacy adherence, including providing disease and medication management.
- Processing and payment of all pharmacy services billed on medical and institutional claims.
- Participating in meetings related to the Medi-Cal Global Drug Utilization Review Board and other Department-driven pharmacy committee meetings.

14. What roles and responsibilities will the Department maintain as of January 1, 2021?

The Department will be responsible for activities including, but not limited to, the following:

- Developing, implementing, and maintaining all Medi-Cal pharmacy policy, including, but not limited to:
  - Drug coverage
  - State supplemental drug rebates
  - Prior authorization/utilization management
- Negotiation of, and contracting for, state supplemental drug rebates.
- Reviewing and issuing final determinations regarding all prior authorization denials for Medi-Cal Rx benefits.
- Providing oversight of, and facilitation for, the State Fair Hearing process.
- Establishing Medi-Cal Rx pharmacy reimbursement methodologies, consistent with applicable state and federal requirements.
- Establishing and maintaining the Medi-Cal pharmacy provider network.

- Overseeing the Medi-Cal Global Drug Utilization Review Board and other Department-driven pharmacy committees, in collaboration with the Medi-Cal Rx Contractor.
- Contract management and oversight/monitoring of the Medi-Cal Rx Contractor.

15. What roles and responsibilities will the Medi-Cal Rx Contractor assume as of January 1, 2021?

The Medi-Cal Rx Contractor will be responsible for activities including, but not limited to, the following:

- Providing claims administration, processing, and payment functionalities for all pharmacy services billed on pharmacy claims.
- Overseeing coordination of benefits with other health coverage, including Medicare.
- Providing utilization management functionalities, including ensuring pharmacy prior authorization adjudication occurs within 24 hours (note: all pharmacy prior authorization denials will require the Department's review prior to final determination).
- Providing Prospective and Retrospective Drug Utilization Review (DUR) services.
- Providing drug rebate administration services, which are compliant with federal and state laws, and adhere to the Department's policies and direction.
- Providing twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year, excluding approved holidays, or unless otherwise directed by the Department, Customer Service Center to support all provider and beneficiary calls, as well as outreach, training, and informing materials.
- Providing data feeds (at least daily) to Medi-Cal Managed Care Plans, Mental Health Plans, and Substance Use Disorder Plans to support their responsibilities of beneficiary care coordination, carrying out clinical aspects of pharmacy adherence, and disease and medication management.
- Providing real-time access into the Medi-Cal Rx Contractor's electronic environment via a secure portal to all Medi-Cal providers (prescribers and pharmacies) and Medi-Cal Managed Care Plans, Mental Health Plans, and Substance Use Disorder Plans.
- Providing direct Medi-Cal Managed Care Plans liaisons to assist with care coordination and clinical issues.

16. How will the Department ensure that the Medi-Cal Rx Contractor does not use patient data, including prescription information, for any purpose other than Medi-Cal Rx administrative services?

The requirements for appropriate use of Medi-Cal beneficiary information are outlined, clearly and in detail, in Medi-Cal Rx Request for Proposal #19-96125, which will become part of the final executed contract language. In addition, the Medi-Cal Rx Contractor is required to

adhere to all existing state and federal requirements as well as the Department's policies relating to sensitive data and privacy.

17. Where can I find more information about the Medi-Cal Rx Request for Proposal #19-96125?

For more information about Medi-Cal Rx Request for Proposal #19-96125, please visit the FI$Cal/Cal eProcure website. Final Proposals were due by October 1, 2019 at 4:00 PM PDT. Please continue to check the Department's website for updates. Additional questions regarding may be submitted to the Department via email at CSBRFP1@dhcs.ca.gov.

TRANSITION INFORMATION

18. Will Medi-Cal Rx use a "phased" approach to transition services?

No, effective January 1, 2021, the Medi-Cal pharmacy benefit will transition from the Medi-Cal managed care delivery system to fee-for-service delivery system (collectively "Medi-Cal Rx"). At the same time, the new Medi-Cal Rx Contractor will assume responsibility for all administrative services necessary to support Medi-Cal Rx, including but not limited to, claims management, prior authorization and utilization management, pharmacy drug rebate administration, provider and beneficiary support services, and other ancillary and reporting services. As mentioned in a prior response, this transition is a critical step of the broader **Medi-Cal Healthier California for All initiative (formerly known as CalAIM)** being proposed by the Department.

19. How will the Department ensure that the knowledge and experience of Medi-Cal Managed Care Plans, and other stakeholders, is leveraged in the transition process to achieve a successful continuity of services?

The Department has proactively engaged external partners in multiple ways and through multiple avenues, to ensure that knowledge and experience is leveraged to make Medi-Cal Rx successful. The Department intends to continue these types of engagement efforts and is committed to working with its external partners, including Medi-Cal Managed Care Plans, counties, providers, consumer advocates, and beneficiaries, to ensure a smooth and successful transition. For example, the Department has established a dedicated Medi-Cal Managed Care Plan workgroup that will meet regularly to discuss various issues, identify best practices, and provide workable solutions and strategies to support the Department's implementation efforts.

Going forward, the Department will also continue to actively explore opportunities to streamline and enhance existing stakeholder engagement and outreach efforts around Medi-Cal, which will include targeted Medi-Cal Rx workgroup meetings and discussions to collaborate on best practices and implementation strategies that meet the needs of all impacted parties.

20. How will information about the Medi-Cal Rx transition and other related changes be communicated?

The Department will work in collaboration with the Medi-Cal Rx Contractor to ensure all interested parties (including, but not limited to, Medi-Cal Managed Care Plans, Mental Health Plans, Substance Use Disorder Plans, providers, and beneficiaries) are informed of transition and other related changes. Although exact timelines are still under development, communication will be disseminated via several methods including, but not limited to:

- A series of trainings and educational materials for Medi-Cal providers four to six months prior to transition; additional details will be communicated in the coming months.
- Notices to Medi-Cal beneficiaries, Managed Care Plans and fee-for-service providers, at defined intervals; additional notices will be released, as needed.
- Medi-Cal Managed Care Plan Outbound Call Campaigns to enrolled members.
- Updates to Medi-Cal Managed Care Plan Member Handbook (Evidence of Coverage), as well as informing materials for other impacted entities.
- Updates to the Medi-Cal Provider Manual, as well as new provider guidance and materials published by the Medi-Cal Rx Contractor, as directed by the Department.
- Updates to Medi-Cal Managed Care Plan contracts, as needed, to reflect the transition of the pharmacy benefit from managed care to fee-for-service.
- Updates to the Medi-Cal Managed Care Plans rates.
- Regular updates via existing stakeholder processes and workgroups, including but not limited to, the Department's bi-monthly Stakeholder Communication Update, Medi-Cal Rx Public Forum, Medi-Cal Global Drug Utilization Review Board, Medi-Cal Pharmacy Directors' Meeting, Stakeholder Advisory Committee, California Children Services Advisory Committee, etc.

21. How will the Department ensure Medi-Cal beneficiaries transitioning to Medi-Cal Rx do not experience a disruption in their care and/or inability to access necessary prescription medications?

To assist Medi-Cal beneficiaries, providers (prescribers and pharmacies), and Managed Care Plans with the initial transition on January 1, 2021, the Department will provide for a minimum 90-day pharmacy transitional period to facilitate a smooth, productive transition, ensuring that Medi-Cal beneficiaries do not experience disruption in their access to medically necessary prescriptions while maintaining compliance with all state and federal laws related to the Medi-Cal pharmacy benefit. More detailed information regarding the Medi-Cal Rx 90-day transitional period will be released in future guidance from the Department.

22. Will the Department develop a Medi-Cal Rx transition plan, and, if so, what components will that plan include?

Yes, pursuant to the requirements outlined in Request For Proposal #19-96125, Exhibit A, Attachment I – Scope of Work – Takeover, the Medi-Cal Rx Contractor will develop a Medi-Cal Rx pharmacy transition approach/plan to include, at a minimum, processes for:

- Providing sufficient notice and flexibility for Medi-Cal pharmacies and prescribers to take all necessary steps to acclimate to the new Medi-Cal Rx Contractor, the Medi-Cal Contract Drugs List, and associated processes.
- Providing appropriate notice and related materials from the Department and Medi-Cal Managed Care Plans to Medi-Cal beneficiaries regarding the transition.
- Providing temporary flexibility for obtaining prior authorization on drugs dispensed during the transition period by allowing ongoing (drug treatments initiated prior to January 1, 2021) and newly prescribed drugs to be dispensed and billed without first having an approved prior authorization. However, prospective Drug Utilization Review requirements for drug safety will still apply.
- Pharmacy, provider, and beneficiary assistance, including ensuring that affected parties receive appropriate notification of, and additional information related to, the Medi-Cal Rx pharmacy transitional period and related processes.

23. Should Medi-Cal Managed Care Plans discontinue and/or void any prior authorizations that were adjudicated and approved by the Medi-Cal Managed Care Plan on or before December 31, 2020?

No, Medi-Cal Managed Care Plans should not discontinue and/or void such prior authorizations, and should similarly not have authorizations automatically expire on December 31, 2020. Both the Department and Medi-Cal Managed Care Plans should take necessary steps to ensure Medi-Cal beneficiaries continue to have access to medically necessary pharmacy benefits and services during the transition to Medi-Cal Rx.

DATA FEEDS, ELECTRONIC ACCESS & OTHER CLINICAL SUPPORTS

24. Will Medi-Cal Rx provide the pharmacy data and necessary electronic access for Medi-Cal providers, Medi-Cal Managed Care Plans, and other entities to support care coordination?

Yes, Medi-Cal Rx will provide data feeds (at least daily) to Medi-Cal Managed Care Plans, Mental Health Plans, and Substance Use Disorder Plans to support their responsibilities of beneficiary care coordination, carrying out clinical aspects of pharmacy adherence, and disease and medication management.

In addition, Medi-Cal Rx will provide real-time access into the Medi-Cal Rx Contractor's electronic environment via a secure portal to all Medi-Cal providers (prescribers and

pharmacies) and Medi-Cal Managed Care Plans, Mental Health Plans, and Substance Use Disorder Plans.

25. What additional clinical and care coordination support will Medi-Cal Rx provide to Medi-Cal Managed Care Plans?

Medi-Cal Rx will provide additional care coordination support to Medi-Cal Managed Care Plans to meet their contractual obligations relating to Medi-Cal beneficiary care coordination, medication adherence, and other related responsibilities, by:

- Providing a dedicated Medi-Cal Managed Care Plan liaison team to interface with the Medi-Cal Managed Care Plans, other Contractor staff, and the Contractor's portal/environment to assist with and resolve clinical pharmacy-related issues for Medi-Cal Rx, including those involving prior authorization, as directed by the Department.
- Maintaining sufficient staffing ratios of dedicated Medi-Cal Managed Care Plan liaisons to ensure this level of access is maintained for Medi-Cal Managed Care Plans.

PROVIDER OUTREACH, EDUCATION & TRAINING

26. What kinds of provider outreach, education, and training, as well as related supports, is the Department offering and/or planning to do for Medi-Cal Rx?

The Department, in collaboration with the Medi-Cal Rx Contractor, is dedicated to providing Medi-Cal provider customer support services, including but not limited to, the following:

- Twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year, excluding approved holidays, or unless otherwise directed by the Department, customer services center to support all provider calls.
- Outreach, training and informing materials to Medi-Cal providers, Medi-Cal Managed Care Plans, and other entities.
- Web-based services to support communication and tools for Medi-Cal Rx.
- Real-time access into the Medi-Cal Rx Contractor's electronic environment via a secure portal.
- Other services and supports to ensure a smooth and effective transition (e.g., minimum 90 day pharmacy transitional period).

In addition, the Medi-Cal Rx Contractor's Pharmacy Service Representatives will act on behalf of the Department to relay and provide subject-matter expertise/support regarding Medi-Cal Rx information and training materials to providers (prescribers and pharmacies) pharmacy billing agents, and plan partners, in a variety of venues. For more information, please see Request For Proposal #19-96125 Exhibit A, Attachment II – Scope of Work – Operations – Education and Outreach.

BENEFICIARY CUSTOMER SERVICE & RELATED SUPPORTS

27. What kinds of Medi-Cal beneficiary customer service and related supports is the Department offering and/or planning to do for Medi-Cal Rx?

The Department, in collaboration with the Medi-Cal Rx Contractor, is dedicated to providing beneficiary customer services and related supports, including but not limited to, the following:

- Twenty-four (24) hours per day, seven (7) days per week, three hundred and sixty-five (365) days per year, excluding approved holidays, or unless otherwise directed by the Department, customer services center to support all beneficiary calls.
- Informing materials related to Medi-Cal Rx through different avenues, including but not limited to appropriate notices via U.S. Mail and web-based services (e.g., external facing internet webpage to support communication and tools for Medi-Cal Rx).
- A Medi-Cal Rx Pharmacy Locator Tool (MPL) that is available through the Pharmacy Service Portal to include all Medi-Cal Rx eligible pharmacies.
- An Interactive Voice Response (IVR) system to provide:
    - Recorded information
    - Self-service options
    - Ability to request follow-ups from customer service, such as a call back phone call, information to be provided by mail or email

In addition, the Medi-Cal Rx Contractor's Pharmacy Service Representatives will act on behalf of the Department to relay and provide subject-matter expertise/support regarding Medi-Cal Rx information and related materials to Medi-Cal beneficiaries, in a variety of venues. For more information, please see Request For Proposal #19-96125 Exhibit A, Attachment II – Scope of Work – Operations – Education and Outreach.

MEDI-CAL FEE-FOR-SERVICE REIMBURSEMENT METHODOLOGY

28. For Medi-Cal pharmacies, how is the Medi-Cal fee-for-service pharmacy reimbursement methodology established, and what are the components?

Medi-Cal fee-for-service pharmacy reimbursement for covered outpatient drugs, as defined by the federal Centers for Medicare and Medicaid Services (CMS) and in the Medi-Cal State Plan, has two components, consistent with applicable state law: (1) drug ingredient cost (average acquisition cost), and (2) a professional dispensing fee (two-tiered based on total Medicaid and non-Medicaid annual pharmacy claim volume (i.e., dispensed prescriptions):

- < 90,000 claims per year: $13.20
- > or = 90,000 claims per year: $10.05

For 340B claims, reimbursement is covered entity's actual drug acquisition cost plus the appropriate professional dispensing fee.

29. As a result of Medi-Cal Rx, will the Department be making changes to existing fee-for-service pharmacy reimbursement methodologies, including for specialty drugs?

The Department will utilize drug reimbursement methodologies as defined in state law and the Medi-Cal State Plan. If the Department implements the use of Maximum Allowable Ingredient Costs (MAICs) for drugs, which have three (3) or more generically equivalent options available, reimbursement for the affected drug(s) may change if the MAIC is "lesser of" the two other benchmarks defined in state law, i.e., National Average Drug Acquisition Cost and Federal Upper Limit.

POLICY CONSIDERATIONS

30. What is Medi-Cal's Contract Drug List?

The Department maintains the Medi-Cal Contract Drug List, which is the Department's preferred set of covered drugs and generally includes drugs for which there is a current state supplemental drug rebate agreement in place. Under the existing Medi-Cal fee-for-service pharmacy benefit, if a drug is listed on the Medi-Cal Contract Drug List, then it would not require an approved prior authorization for coverage. Alternatively, if a drug is not listed on the Medi-Cal Contract Drug List, then it would require an approved prior authorization for coverage. Please note that even if a drug is listed on the Medi-Cal Contract Drug List, it may still require an approved prior authorization for coverage; however, if a certain drug on the Medi-Cal Contract Drug List requires an approved prior authorization, then the Department's policy would clearly articulate that requirement.

31. How will Medi-Cal Rx affect Medi-Cal's Contract Drug List, and does the Department take anything else into consideration for its Medi-Cal drug coverage policies?

Medi-Cal Rx will use the existing Department-approved Medi-Cal Contract Drug List as its preferred set of covered drugs. In addition, the Department's pharmacy drug coverage policies will also take into consideration:

- All Federal Food and Drug Administration-approved covered outpatient drugs, as defined by CMS, subject to medical necessity.
- The Department's business rules that detail requirements for the covered outpatient drugs and non-drug products, and limitations of coverage, which include aid code, program, and/or date-specific.

32. Will Medi-Cal Rx consider local exceptions to Medi-Cal's Contract Drug List?

No. Medi-Cal Rx will use a single, statewide, and Department-approved Medi-Cal Contract Drug List to standardize the Medi-Cal pharmacy benefit.

33. How does the Department make determinations to add or delete drugs from the Contract Drug List?

The Department can add drugs to the Medi-Cal Contract Drug List based upon receipt of either (1) an external Individual Drug Petition request from a manufacturer, physician, and/or pharmacist, or (2) a Department-initiated Individual Drug Petition review, if applicable. Once an IDP is received, the Department conducts an extensive review of the request taking into consideration evidence-based literature, industry best practices, and the following drug review criteria, which are outlined in Welfare and Institutions Code Section 14105.39(c)(1) and (2):

- The safety of the drug
- The effectiveness of the drug
- The essential need of the drug
- The potential for misuse of the drug
- The cost of the drug to the program

In addition to conducting its own internal review, the Department also consults with the Medi-Cal Drug Advisory Committee (Committee), as required by Welfare and Institutions Code Section 14105.4. The Committee is comprised of members who are appointed by the Department's Director – including community physicians and pharmacists, faculty members from academic pharmacy institutions, and Medi-Cal beneficiaries – and assists the Department by providing written recommendations to inform decision-making regarding adding and/or deleting, drug(s) from the Medi-Cal Contract Drug List. The Committee's final response with detailed, drug-by-drug recommendations is due within 30 calendar days of the Department requesting consultation, and takes into consideration the Welfare and Institutions Code Section 14105.39(c)(1) and (2) criteria, as well as additional information such as generic name, brand name, Federal Food and Drug Administration-approved indications, manufacturer, fiscal/cost impact, clinical criteria, etc.

The Department then makes an informed and documented decision whether or not to add the drug to the Medi-Cal Contract Drug List based upon the Committee's recommendations, state law requirements, and other relevant factors.

34. Will the Department be considering any statutory changes related to Medi-Cal Rx? Yes, the Department is proposing Trailer Bill as part of the Governor's budget, which would:

- **Repeal the six-prescription ("6 Rx") drug limit.**
- **Eliminate the Medi-Cal fee-for-service (FFS) prescription co-pays.**
- **Establish a "best pricing" schedule for Medi-Cal drugs that would allow for drug prices outside the United States to be considered.**

35. Will the Department consider making policy changes to allow for multi-year prior authorization approvals?

As part of Medi-Cal Rx, the Department is considering allowing multi-year prior authorization for certain disease conditions and classes of drugs based upon established and documented clinical criteria (e.g. maintenance drugs with a low risk of adverse events). The following are potential categories of drugs for consideration: anti-hypertensives, diabetes management, anticonvulsants, asthma therapy, Parkinson's Disease therapy, etc.

36. Will the Department consider making policy changes to allow for enhanced and/or expanded auto-adjudication functionalities?

As part of Medi-Cal Rx, the Department is considering enhancing and/or expanding auto-adjudication functionalities (i.e., automated claim approval and payment) to reduce the number of drugs with prior authorization requirements that require manual review. The following are potential categories of drugs for consideration: nonsteroidal anti-inflammatory drugs (NSAIDs), histamine-2 receptor blockers (H2 Blockers), proton pump inhibitors (PPIs), discharge medications, selective serotonin reuptake inhibitors (SSRIs), antihistamines, lipid lowering medications, diuretics, etc.

37. Will Medi-Cal Rx include opioid management services?

Medi-Cal Rx will provide opioid management services in accordance with House Resolution 6 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, Medi-Cal pharmacy policy and procedures, and clinically appropriate, evidence-based guidelines. In addition, as part of Medi-Cal Rx, the Department has solicited Proposals as part of the Request for Proposal to further explore enhanced opioid management utilization management tools that go above and beyond what is required by federal law. The Department will evaluate all Proposals received.

38. Will Medi-Cal Rx include a pharmacy lock-in program?

As part of the Medi-Cal Rx Request for Proposal #19-96125, the Department has solicited Proposals to explore further pharmacy lock-in program options, including, but not limited to, things such as: use of multiple pharmacies, different prescribers of controlled substances, and number of controlled substances. The Department will evaluate all Proposals received. In addition, the Department is aware that approximately 50 percent of Medi-Cal Managed Care Plans utilize pharmacy lock-in programs today, so through stakeholder engagement efforts, the Department will be looking to learn more and utilize best practices for Medi-Cal Rx.

PRIOR AUTHORIZATION/UTILIZATION MANAGEMENT

39. Under Medi-Cal Rx, how will prior authorization requests be reviewed and adjudicated?

For all prior authorization requests, the Medi-Cal Rx Contractor will ensure that within 24 hours, the Medi-Cal provider will receive a confirmation and/or notice of approval, deferral,

modification, and/or referral to second level-review, as directed by the Department. This includes the Medi-Cal Rx Contractor's pharmacist's review of all denials.

- If approved, the Medi-Cal Rx Contractor will notify the submitting Medi-Cal Rx provider.
- If deferred (more information is needed), the Medi-Cal Rx Contractor will notify the provider and beneficiary, and complete processing if information is provided in the specified timeframe, as directed by the Department.
- If denial is recommended, the prior authorization request along with the Medi-Cal Rx Contractor's pharmacist's reasoning for denial will be referred to the Department for final determination, as described in question #38 below.
- If service is deferred, denied or modified, the Contractor will notify the provider and mail appropriate notice to the beneficiary within three (3) business days.

Throughout the process, Medi-Cal providers and Managed Care Plans will be able to communicate with Medi-Cal Rx Contractor staff and access the Medi-Cal Rx Contractor's electronic environment via a secure portal to assist with and resolve clinical pharmacy-related issues, including questions/concerns around Medi-Cal Rx timelines and decisions related to pending prior authorization requests.

40. What is the process for reviewing and resolving Medi-Cal Rx prior authorization denials?

The Department will be responsible for reviewing and providing a final adjudication of all Medi-Cal Rx prior authorization denials within the timeframes specified in applicable state law and internal policies/processes. Once the Department completes its review, it will recommend to the Medi-Cal Rx Contractor one of several outcomes, which are described below, by inputting the final prior authorization decision into the Medi-Cal Rx Contractor's electronic environment via a secure portal:

- Defer approval until additional information is received from the submitting Medi-Cal Rx provider.
- Reverse the Medi-Cal Rx Contractor's denial, and recommend approval.
- Confirm and uphold the Medi-Cal Rx Contractor's denial. If the Medi-Cal Rx denial is upheld, the Medi-Cal provider will receive appropriate notice and can appeal consistent with the requirements outlined in Request For Proposal #19-96125, Exhibit A, Attachment II – Scope of Work Operations – Claims Administration, and consistent with applicable state law requirements and Department policies/procedures.

More detailed information regarding the Medi-Cal Rx prior authorization denial process will be released in future policy guidance. Please note, as described elsewhere in this document, the Medi-Cal beneficiary also has the option to appeal a Medi-Cal Rx prior authorization denial through the State Fair Hearing process.

41. Will Medi-Cal Managed Care Plans be allowed to contract with the Medi-Cal Rx Contractor to perform prior authorization?

No. Since Medi-Cal Managed Care Plans will no longer be contractually responsible for the Medi-Cal pharmacy benefit as of January 1, 2021, all prior authorization adjudications and related processes will be handed by the Medi-Cal Rx Contractor, consistent with contractual requirements and at the direction of the Department.

340B FEDERAL DRUG DISCOUNT PROGRAM

42. What is the federal 340B program?

Section 340B of the Public Health Services Act (Title 42 United States Code Section 256b), establishes a federal program known as the 340B Drug Pricing Program (340B program), which was created in 1992 after the adoption of the Medicaid Drug Rebate Program. The Health Resources and Services Administration, an agency under the United States Department of Health and Human Services, administers and manages the program through its Office of Pharmacy Affairs.

The 340B program requires drug manufacturers to offer drugs to certain hospitals and other health care providers (covered entities) at a greatly reduced price. By selling drugs at lower prices, participating drug manufacturers are not required to pay Medicaid drug rebates on drugs purchased through the 340B program and provided to a Medicaid beneficiary (better known as the provision against “duplicate discounts”).

43. Who utilizes the 340B program?

Section 340B(a)(4) of the Public Health Services Act (Title 42 United States Code Section 256b) specifies which covered entities are eligible to participate in the 340B program. These include qualifying hospitals, federal grantees from the Health Resources and Services Administration, the Centers for Disease Control and Prevention, the Department of Health and Human Services’ Office of Population Affairs and Indian Health Service. Eligible covered entities are defined in statute and include HRSA-supported health centers and look-alikes, Ryan White clinics and State AIDS Drug Assistance programs, Medicare/Medicaid Disproportionate Share Hospitals, children’s hospitals, and other safety net providers.

When registering as a covered entity with the Health Resources and Services Administration, a covered entity may choose to not dispense 340B purchased drugs to Medicaid beneficiaries or to dispense 340B purchased drugs to Medicaid beneficiaries. HRSA maintains a file of covered entities that indicates whether the entity dispenses 340B purchased drugs to Medicaid patients. Although covered entities can purchase 340B drugs for all eligible patients, state Medicaid programs may only collect rebates on drugs purchased outside of the 340B program. Additional details are available on the Health Resources and Services Administration’s website.

44. What is the interaction of our prescription drug proposal and the 340B program?

Drugs purchased under 340B pricing and dispensed to Medicaid enrollees are excluded from both federal and state rebate collection. This exclusion prevents drug manufacturers from providing duplicate discounts on drugs purchased through the 340B program.

In October 2009, California codified a pre-existing policy that requires 340B covered entities to dispense only 340B inventory to Medi-Cal beneficiaries, and bill at their actual acquisition cost for those drugs when dispensed through the Medi-Cal fee-for-service delivery system, consistent with Welfare and Institutions Code Section 14105.46. The 340B actual acquisition cost billing requirement only applies to the fee-for-service delivery system.

In the managed care delivery system, 340B drugs dispensed to Medi-Cal beneficiaries are not subject to the Medi-Cal fee-for-service acquisition-cost billing requirements. This allows covered entities and the Medi-Cal Managed Care Plans and/or contracted Pharmacy Benefits Managers to negotiate reimbursement arrangements that results in a higher reimbursement to the 340B covered entity in the managed care delivery system when compared to how those entities are or would be reimbursed in the Medi-Cal fee-for-service delivery system. These profits are not shared with the state, nor are the amounts of such profits known to the state.

The proposed prescription drug carve out allows for uniformity of policy and improved oversight of claims for medications dispensed and billed through the 340B program.

45. Does the proposal preclude a provider from continuing as a 340B entity?

No. In addition, the proposal does not change or eliminate the 340B Program in California.

46. How is the Department addressing the concerns raised as to the effect of Medi-Cal Rx on the administration of 340B programs?

The Department recognizes the important role of our safety net providers and the critical work they do for Medi-Cal beneficiaries. Given this, the Department **has worked and** continues to work collaboratively and engage in discussions with various interested parties and stakeholders on behalf of health care facilities and groups to better understand the impact of the implementation of Medi-Cal Rx on their 340B programs and related processes, as well as to further discuss potential options for mitigation.

47. Has the Department collected any data or information to assess the impact to the 340B Program?

The Department has engaged interested parties and stakeholders to participate in a 340B data collection effort. In October, the Department requested that all clinics/health centers download and complete the provided data template in full and submit it to the Department. The Department **has** assess**ed** the level of participation and completeness of the data provided in these submissions, and us**ed** this information to compile statewide data in order to inform discussions within the Administration and with the Legislature and clinics/health centers. **As a result, DHCS is proposing a new supplemental payment pool for non-**

hospital 340B clinics as a part of the Governor's 2020-21 Budget. This program would become effective with the Medi-Cal Rx transition date of January 1, 2021. The size of the supplemental payment pool is $105 million Total Fund on an annual basis, which was based off of the information from the data submitted by the non-hospital 340B clinics.

MEDI-CAL RX COMPLAINTS/GRIEVANCES RESOLUTION & APPEALS PROCESSES

48. What complaints and grievances resolution processes will Medi-Cal beneficiaries have to address pharmacy benefit issues?

The Medi-Cal Rx Contractor will be responsible for managing a process to ensure resolution of complaints and grievances raised by Medi-Cal beneficiaries and/or their Authorized Representatives (ARs), either in writing or by telephone, consistent with all applicable state and federal law requirements and Department policies/procedures. Specific requirements are outlined in Request For Proposal #19-96125, Exhibit A, Attachment II – Scope of Work Operations – Complaints and Grievances Resolution.

49. What appeals mechanism will Medi-Cal beneficiaries have to address pharmacy benefit issues?

Appeals go through the State Fair Hearing process, which is administered through the California Department of Social Services. If Medi-Cal beneficiaries do not agree with a denial or change of Medi-Cal Rx services, they can ask for a State Fair Hearing. To ask for a State Hearing, Medi-Cal beneficiaries can fill out the "State Hearing Request" form at www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx, and send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

Medi-Cal beneficiaries may also call to ask for a State Fair Hearing toll-free at 1(800) 952-5253 (TTY:1-800-952-8349). Please note that the number can be very busy so you may get a message to call back later.

50. If a Medi-Cal beneficiary wants a State Fair Hearing, are there any time limitations?

Yes, Medi-Cal beneficiaries only have 90 days to ask for a hearing, consistent with applicable state law.

51. Can Medi-Cal beneficiaries still get their treatment while awaiting a State Fair Hearing decision?

Yes. To continue receiving the Medi-Cal Rx services that the denial notice is stopping and/or changing, Medi-Cal beneficiaries must ask for a State Hearing within ten days from:

- The date the notice is postmarked

- The date of personal delivery of the notice
- Before the date the notice says your treatment will stop or change

When requesting the State Fair Hearing, Medi-Cal beneficiaries should indicate that they want to keep getting Medi-Cal Rx services during the hearing process. Please note that it can take up to 90 days for a case to be decided and a final determination to be sent to the Medi-Cal beneficiary.

52. Can Medi-Cal beneficiaries request an expedited State Fair Hearing?

Yes. Medi-Cal beneficiaries can request an expedited hearing by submitting a letter from their doctor explaining how waiting for up to 90 days could be risky to their life and/or health. Medi-Cal beneficiaries should send the letter along with their hearing request. For more information about the State Hearing process, please visit the Department's website at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx.

53. For appeals of Medi-Cal Rx coverage decisions by the Medi-Cal provider and/or Managed Care Plan, will the Department create a separate Medi-Cal Rx external appeal process where independent medical experts review decisions?

No, at this time, the Department is not exploring creating a separate independent medical review process, akin to that currently overseen by the California Department of Managed Health Care, for Medi-Cal Rx. As a reminder, Medi-Cal Rx denials for pharmacy claims will not be made by Medi-Cal providers and/or Managed Care Plans, rather they will initially be made by the Medi-Cal Rx Contractor and reviewed by the Department for final determination. As mentioned elsewhere in this document, Medi-Cal providers can appeal Medi-Cal Rx denials consistent with the requirements outlined in Request For Proposal #19-96125, Exhibit A, Attachment II – Scope of Work Operations – Claims Administration, and applicable state law requirements and Department policies/procedures

FISCAL IMPACT/ASSESSMENT

54. Will the Department be completing a fiscal analysis prior to the transition?

Yes The Department has completed a fiscal analysis for Medi-Cal Rx, and has shared this information publicly The Department anticipates approximately **$405 General Fund** million in annual savings by 2022-23. The Department will be including the fiscal estimate for Medi-Cal Rx as part of the bi-annual Medi-Cal Estimate process.

55. What are the elements of our projected $405 million General Fund (GF) in annual savings by 2022-23?

The elements of the projected $**405** million **GF** savings by 2022-23, include but are not limited to **the following factors**:

- Additional **state** supplemental **drug** rebates resulting from a shift of drug utilization from the managed care delivery system to the FFS delivery system;

- Implementation of Maximum Allowable Ingredient Costs (MAICs) for drugs which have three (3) or more generically equivalent options available; and
- Reduction of costs related to administrative functions of multiple pharmacy benefits managers used by various Medi-Cal Managed Care Plans.
- **Fiscal is based on current Medi-Cal fee-for-service (FFS) reimbursement methodology, which includes $10.05/$13.20 dispensing fees.**
- **Based on current FFS reimbursement methodology, including the $10.05/$13.20 dispensing fees,** 340B drugs were priced at what Managed Care Plans paid due to the Department not having knowledge of the 340B entity acquisition cost to properly score the potential 340B savings.
- In addition, **DHCS is also proposing a new supplemental payment for non-hospital 340B clinics as a part of the Governor's 2020-21 Budget, effective with the Medi-Cal Rx transition date of January 1, 2021. See question #47 above for more detailed information.**

MISCELLANEOUS/OTHER INFORMATION

56. Will Medi-Cal Rx include mail order pharmacy options?

Yes. Mail-order options are available in Medi Cal today, and will continue to be available through Medi-Cal Rx. If the pharmacy is an approved Medi-Cal pharmacy provider, the pharmacy may dispense the medication on site or through a mail-order service. The Department will work with the Medi-Cal Rx Contractor to ensure continuation of an effective mail-order service option for Medi-Cal pharmacy services.

57. Will the Department make Medi-Cal pharmacy supplemental drug rebate contracts public?

No. Both state and federal law protect the confidentiality of supplemental drug rebate contracts.

58. Will the Medi-Cal Rx Contractor be required to contract with existing pharmacies in the current networks?

No. The Medi-Cal Rx Contractor will not contract with any providers. All provider enrollment activities as well as maintenance of the Medi-Cal pharmacy network will be retained by the Department.

59. How many active, California-licensed pharmacies are there, and how many of those pharmacy providers are enrolled in Medi-Cal fee-for-service?

As of May 2018, data from the Department of Consumer Affairs indicated that there were 6,633 active, California-licensed pharmacies. As of June 2019, data from the Department indicated that 6,223 were enrolled Medi-Cal fee-for-service pharmacy providers.

60. In what capacity will Medi-Cal Managed Care Plans and other entities be expected to participate in meetings for the Medi-Cal Global Drug Utilization Review Board and other Department-driven pharmacy committees?

Presently and ongoing post-transition, the Department expects that its Medi-Cal Managed Care Plans and other interested parties will continue to participate in meetings related to the Medi-Cal Global Drug Utilization Review Board and in other Department-driven pharmacy committees, as needed. In addition, the Department is actively evaluating and assessing how to better and more effectively engage and collaborate with Medi-Cal Managed Care Plans and other entities in discussions and decisions relating to Medi-Cal pharmacy policy on a going forward basis.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Ratification of Temporary Operational Changes to the Program of All-Inclusive Care for the Elderly (PACE) Related to Coronavirus Pandemic

Contact
David Ramirez, Chief Medical Officer, 714-246-8400

Recommended Actions
Ratify the following temporary operational changes made by CalOptima PACE management in response to the Coronavirus (COVID-19) pandemic:
1. Provision of skilled home health services by qualified CalOptima PACE employees; and
2. Updated job descriptions for qualified employees to provide home health services

Background
CalOptima PACE currently serves approximately 382 participants via the CalOptima PACE Center and four operating alternative care settings. PACE is a nursing home alternative for individuals requiring nursing home level of care but are able to continue living safely in the community. The average age of PACE participants is 73. PACE participants have multiple co-morbidities, presenting as the highest risk population for complications from COVID-19.

Staff continue to take actions to reduce the spread of COVID-19 and maintain the health of PACE participants in the community. The operational changes made thus far represent a significant reinvention of the PACE model to a home-based system of care, which support staff are calling "PACE Without Walls." To comply with physical distancing recommendations from the Centers for Disease Control and Prevention (CDC), PACE congregate services, including center recreational activities and meals, have been suspended. The clinic and rehabilitative therapies operate with limited in-person visits. All other services now rely on drive-thru, telephonic and virtual visits.

Until a vaccine or effective therapeutic treatment for COVID-19 is available, CalOptima PACE management anticipates that services will be provided through PACE Without Walls. As part of its PACE presentation to the CalOptima Board of Directors at its May 7, 2020 meeting, staff indicated its intention to continue identifying gaps in service and respond accordingly.

Discussion
While the PACE model of care requires the PACE program to either contract or maintain a license for home health services, since launching the program in 2013, CalOptima operates according to the former. The following narrative explains the events that lead to certain temporary operational changes permissible during the current public health emergency; however, the specific changes that require Board ratification include:
- Provision of skilled home health services by qualified CalOptima PACE employees
- Updated job descriptions for qualified employees to provide home health services

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Over the past six years, certain PACE positions have the experience of completing assessments, health education, training and family conferences in participants homes. These in-home services were postponed, effective March 23, 2020, due to the risk for staff exposure and spread of COVID-19. Through flexibilities granted by regulatory agencies (California Department of Public Health, All Facility Letter 20-34 dated April 2, 2020) related to the current public health emergency, PACE has flexibility on how and where to provide skilled services to participants. Specifically, utilization of center-based personnel to perform tasks in participants homes is authorized. Reinstating and building on experience and leveraging temporary flexibilities, as the County of Orange resumes activities, PACE Without Walls expands in-home services to include services described in the table below:

	Pre-COVID Operations (On Hold since 3/23/2020)	**Temporary Additions to Operations**
Positions	Home Care Coordinator (4), Social Worker (7), Physical Therapy (4), Occupational Therapy (2)	Personal Care Attendant (3)
Encounter Type	Assessment, health education, training, family conference	Skilled interventions, non-skilled personal care
Equipment	Laptop, Mifi device	PPE, supply bag
Training	12 modules on PACE operations and care for the elderly	New module and skills check for in-home services
Compensation	Mileage reimbursement, hourly rate	No change
Estimated Volume	60 encounters / month	120 encounters / month

Potential increased exposure risk for auto coverage, workers' compensation, and medical malpractice due to moving employees to perform services in participants' homes was evaluated. CalOptima's current workers' compensation, auto coverage and medical malpractice carriers were consulted on potential increased exposure risk. No changes in premium or policy were required, as the insurance carriers will absorb this risk related to the public health emergency. Job descriptions for the identified positions were amended to include in-home services. In-home services training with a skills competency check was required prior to rendering in-home services. PACE purchased rolling supply bags and appropriate personal protective equipment (PPE) that was furnished to the assigned personnel. On June 18, 2020, the California Department of Health Care Services, Integrated Systems of Care Division was notified of CalOptima's plan to render expanded in-home services under the flexibility. On June 22, 2020, PACE began supplementing contracted home health services with CalOptima personnel providing in-home services as a temporary solution to gaps in service. An evaluation of in-home services effectiveness and outcomes is planned by the PACE Quality Improvement Committee in quarter three of 2020.

No new staff resources are required for these operational changes. Qualified staff not currently working at the PACE center have been rerouted to work in participants' homes. Expenses associated with routing

staff to participant homes is offset by a reduction in transportation costs, as services provided at the PACE center are now rendered in the home environment.

Fiscal Impact
The recommended action to ratify temporary operational changes by CalOptima PACE in response to COVID-19 is projected to be budget neutral.

Rationale for Recommendation
Temporary operational changes are necessary to balance the goals of reducing participant and staff exposure to COVID-19 while continuing to provide care. Not all services are appropriate for virtual care. Supplementing contracted home health providers when service gaps are identified is critical to continuing service provision. As a result, contact with participants in the PACE Center or in the participants' home is necessary to continue care.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Board Action dated May 7, 2020_Item 9. Consider Authorizing Contracts and Funding to Support the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Response to COVID-19

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Authorizing Contracts and Funding to Support the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Response to COVID-19

Contact
David Ramirez, M.D., Chief Medical Officer (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with a:

1. Virtual care solution provider for PACE members recommended by staff through an informal bidding process for the period of May 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $9,500; and

2. Mobile phlebotomy services provider for blood draw services in PACE member homes for the period of April 1, 2020, through June 30, 2020, and authorize unbudgeted expenditures from existing reserves in an amount not to exceed $12,000.

Background
CalOptima PACE currently serves approximately 402 members via the CalOptima PACE center and four operating alternative care settings. Eligibility for PACE is based on individuals requiring nursing home level of care, yet able to continue living in the community safely. The average age of PACE members is 73. PACE members have multiple co-morbidities, presenting as the highest risk population for complications from COVID-19.

Staff are taking definitive action to reduce the spread of COVID-19 and maintain the health of PACE members in the community. The operational changes made thus far represent a significant reinvention of the PACE model to a home-based system of care and support. At this time, the PACE center is closed to visitors. To comply with social distancing recommendations from the Centers for Disease Control (CDC), PACE day center services have been suspended. The clinic continues to operate with extremely limited in-person visits, now relying on drive-thru, telephonic and virtual visits. These operational changes to remote monitoring, telehealth and delivery of critical supplies and medications has been built upon existing contractual relationships. As services gaps are identified, staff plans to continue to recommend additional contractual relationships to meet member needs.

Discussion
Virtual care is a valuable tool for staff to support PACE members in their home environment. As an interim solution, PACE is using FaceTime and GoogleDuo to connect with members and provide virtual visits for doctors, nurses, therapists and social workers. The current COVID-19 response is expected to extend into the coming months and staff recommend a HIPAA-compliant, cross platform virtual care solution. An interdepartmental team of CalOptima staff, including PACE management, Information Services (Security and Applications) managers, a purchasing manager and the Privacy Officer has

reviewed potential solutions based on an established scope of work. Staff estimate that the cost for these services will range from $200 to $1,000 per month, but will vary depending on vendor packages and the number of virtual care users. In accordance with CalOptima Purchasing Policy GA.5002, staff recommend that the Board authorize the CEO to select a vendor based on an informal bidding process, which includes vendor demonstrations of each product in the context of CalOptima system requirements, entering into an agreement with the selected vendor, and the expenditure of unbudgeted funds from reserves in an amount up to $9,500 to cover anticipated licensing fees and associated expenses with virtual care implementation through June 30, 2020.

While virtual care is a valuable tool, not all provider encounters can be accomplished through a virtual platform. Physical components, such as the collection of vitals and blood draws, usually completed in the PACE clinic, are not possible remotely. To reduce the risk of PACE members going to the PACE clinic or a contracted laboratory for blood draw services, staff recommend contracting with a mobile phlebotomy service provider capable of completing home visits for stat and routine blood draw services, including venipuncture blood draws, capillary blood draws, kit draws, as well as specimen collection. Providers in this market often contract for a case or capitated rate. This type of bundled rate structure is common for mobile phlebotomy contracts with HMO, IPA, and other health providers in the community. Staff recommend contracting for a flat rate of up to $65 per visit, to include supplies, order processing, technician personnel, and transportation to reach the member and deliver the specimen to the PACE contracted lab. Access to this service is critical in response to COVID-19, and is also expected to be beneficial post-public health crisis for weekend and stat laboratory orders.

Fiscal Impact

The recommended actions to contract with a telehealth solution for PACE members for the period of May 1, 2020, through June 30, 2020, and to contract with a mobile phlebotomy services provider for the period of April 1, 2020, through June 30, 2020, are unbudgeted items. The fiscal impact to the current year operating budget for both is estimated at $21,500. An allocation from existing reserves will fund the recommended actions. If expenses are anticipated beyond June 30, 2020, staff will address them in the CalOptima Fiscal Year 2020-21 Operating Budget or through separate Board actions.

Rationale for Recommendation

Access to telehealth and mobile in-home phlebotomy are critical to the reinvented PACE model operating in response to COVID-19.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action

/s/ Richard Sanchez *04/29/2020*

Authorized Signature **Date**

Attachment 1 to May 7, 2020 Board of Directors Meeting– Agenda Item 9

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
Doxy LLC	3563 S. Mustang Drive	Ontario	CA	91761
Vsee Labs, Inc.	3188 Kimlee Drive, Suite 100	San Jose	CA	95132
SnapMD, Inc.	121 Lexington Drive, Suite 412	Glendale	CA	91203
Thera-Link	P.O. Box 13709	Birmingham	AL	35202
PhlebExpress	32819 Temecula Pkwy. Suite B	Temecula	CA	92591

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Ratification of Amendment to Health Network Contract with Children's Hospital of Orange County and Authorization of Related Funding

Contact

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

Recommended Actions

1. Ratify amendment to the Children's Hospital of Orange County's Health Network Hospital Contract (Hospital Contract Amendment) incorporating a 60-day review period of the rebased capitation rates (Review Period) and the continuation of pre-amendment base rates through the use of supplemental payments for such Review Period;
2. Authorize unbudgeted expenditures of up to $2.4 million from existing reserves for the Hospital Contract Amendment Review Period supplemental payments; and
3. Make a finding that such Review Period supplemental expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background/Discussion

One of CalOptima's networks is a Physician-Hospital Consortium (PHC) comprised of Children's Hospital of Orange County (CHOC) and the CHOC Physicians Network. As with CalOptima's 11 other Medi-Cal Health Networks, CalOptima contracts with the CHOC PHC on a fixed term basis. Any extensions or renewals of the Health Network contracts are subject to Board approval and made through amendments to the Health Network Contracts. The CalOptima Board of Directors approved an extension for Fiscal Year (FY) 2020-21 on June 4, 2020 for all Medi-Cal Health Networks, including the CHOC pediatric Health Network. The extension was authorized through June 30, 2021. That authorization also included changes to the administration of directed payments and incorporation of rebased capitation payment rates for hospital services.

Upon receiving the amendment to its contract, CHOC expressed concerns that the rebasing process did not take into account the special nature of its pediatric-only PHC model and the adequacy of the new capitation rates. In order to allow additional time for CHOC to validate the data and submit additional analysis for further discussion of the rebased capitation rates, the parties agreed to include a 60-day review period in the amendment. CalOptima staff also agreed, subject to Board approval, that CHOC would continue to receive compensation equivalent to the variance between the pre-amendment base rates and the new base rates, both subject to the application of updated member risk adjustment factors effective July 1, 2020, through supplemental payments for the duration of the Review Period.

While the contract extension was signed by CHOC on June 30, 2020, to ensure continuity of member care, the Review Period is needed to allow additional time for CHOC to provide additional data/ analysis in order for CalOptima to ensure that current hospital capitation rates for the Medi-Cal Classic population are consistent with CalOptima's rebasing principles applicable to all capitated Health Networks.

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Staff from CalOptima and CHOC are working collaboratively to review any additional data or analysis that would impact the Medi-Cal rates. In the event that CalOptima and CHOC are unable to come to agreement on mutually agreeable rates by August 31, 2020, either party may provide notice of termination pursuant to the terms of the CHOC Contract. If it is determined that a higher capitation rate is warranted for the CHOC PHC hospital contract under CalOptima's rebasing principles, staff will return to the Board with recommendations regarding any proposed adjustments to those capitation rates.

For the Review Period of July 1, 2020 through August 31, 2020, CalOptima will provide CHOC Hospital with supplemental payments. The supplemental payments coupled with the rebased payments are intended to provide CHOC with funding at approximately the FY 2019-20 base rates through the 60-day Review Period. The estimated Review Period supplemental payment will equal the difference between the new base rates set forth in Attachment E of the FY 2020-21 executed amendment, and the previous base rates set forth in Attachment E of the Amended and Restated Contract with the updated member risk adjustment factors effective July 1, 2020. In the event of a termination, CHOC would be entitled to retain the supplemental payments received for the Review Period.

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 expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Fiscal Impact
The recommended action to ratify the Hospital Contract Amendment and authorize supplemental payment expenditures during the July 1, 2020 to August 31, 2020 Review Period is unbudgeted. An allocation of up to $2.4 million from existing reserves will fund this action.

Rationale for Recommendation
Providing the Review Period will allow CHOC time to provide additional rate-related data and/or analysis in order for CalOptima to ensure that the FY2020-21 capitation rates are consistent with CalOptima's rebasing principles.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated June 4, 2020; "Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts"

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Children's Hospital of Orange County and CHOC Physicians Network	1120 West La Veta Avenue, Ste. 450	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 4, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorizing Extension and Amendments of the CalOptima Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts

Contact

Michelle Laughlin, Executive Director Network Operations (714) 246-8400
Nancy Huang, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to amend the Medi-Cal Full-Risk Health Network HMO, Shared-Risk, and Physician-Hospital Consortium Health Network contracts to:

1. Extend the term through June 30, 2021;
2. Reflect adjustments in Health Network's capitation rates and add language reflecting that Directed Payments will be made pursuant to CalOptima Policy and Procedures effective July 1, 2020; and
3. Revise the Shared Risk program attachment in the Shared Risk group contracts to align with changes made to Policy FF.1010 related to the description of the Shared Risk budget.

Background/Discussion

CalOptima currently contracts with 12 health networks to provide care to CalOptima Medi-Cal members. The continued renewal of the contracts will support the stability of CalOptima's contracted provider network. CalOptima's current Medi-Cal Full-Risk HMO, Shared-Risk, and Physician-Hospital Consortium Health Network Contracts listed below will expire on June 30, 2020:

Full Risk HMO:
Heritage Provider Network, Inc.
Kaiser Foundation Health Plan, Inc.
Monarch Health Plan, Inc.
Prospect Health Plan, Inc.

Shared Risk:
AltaMed Health Services Corporation
ARTA Western California, Inc.
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates Inc. of Mid Orange County
Talbert Medical Group, P.C.
United Care Medical Group, Inc.

Physician-Hospital Consortium:
CHOC Physician's Network and Children's Hospital of Orange County
AMVI Care Health Network and Fountain Valley Regional Hospital and Medical Center
Family Choice Medical Group, Inc. and Fountain Valley Regional Hospital and Medical Center

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Staff recommends extending the above Health Network contracts for one year, through June 30, 2021. Extension of the Heath Network contracts is essential to ensuring that members assigned to health networks have access to covered healthcare services.

Health Network Capitation Rate Adjustment

Medi-Cal Classic Rebasing: For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Classic capitation rates effective July 1, 2020, following CalOptima's periodic rebasing process. Rebasing ensures capitation rates paid to our Health Network providers include appropriate reimbursement for medical and non-medical expenses.

Medi-Cal Expansion (MCE) Rates: In 2014, Medi-Cal eligibility was expanded to cover single, low-income individuals ages 19-64, known as Medi-Cal Expansion (MCE). The Department of Health Care Services (DHCS) provided additional funding to support newly eligible MCE members, a group separate from the Medi-Cal Classic member population. Due to the absence of any utilization information at the program's inception, capitation rates for MCE members were set based on assumed population risk from the beginning of the expansion to date.

For all Health Network contracts, with the exception of Kaiser Foundation Health Plan, Inc., which is reimbursed according to specific terms set forth in a March 7, 2019 Board action, contract terms will reflect adjusted Medi-Cal Expansion (MCE) capitation rates effective July 1, 2020. DHCS has applied multiple downward adjustments to CalOptima's MCE capitation rates due to a lower average acuity than first anticipated. As such, staff continues to analyze the appropriateness of MCE capitation rates paid to Health Networks. Based on an actuarial analysis of utilization data, additional reductions to MCE capitation rates are appropriate.

Over the course of the program, sufficient time has passed to compile reliable Chronic Disability Payment System (CDPS) diagnostic information necessary for risk adjustment. With the CDPS information now available to make determinations regarding acuity, staff proposes to amend the current Health Network contracts to adjust the MCE rate, either up or down, based on CDPS data. With margins being reduced, it is more important to implement risk adjustment to ensure capitation payments are commensurate with population acuity. Staff has provided notices to the Health Networks that their MCE capitation rate will be risk adjusted starting July 1, 2020.

OB Kick Payment Rate Increase: Per Policy FF.1005f, CalOptima has historically provided all Health Networks a supplemental payment for qualifying covered obstetric delivery services. The current rates, set in 2010 when the Maternity Kick Payment program began, are $793 for professional services and $4,451 for facility fees. For the new contract term, staff recommends authorization to increase these rates to $900 for professional services and $5,000 for facility fees for all Health Networks, with the exception of Kaiser Health Plan, Inc. which is being reimbursed according to the terms set forth in a March 7, 2019 Board Action.

Directed Payments

Periodically CalOptima is required through DHCS or CMS guidance to make statutorily mandated retrospective payments to its Health Networks. These payments are typically based on DHCS programs, including Proposition 56 and the Quality Assurance Fee (QAF) supplemental payments. In many cases these provider supplemental payments have been established and administered over multiple time periods and phases, sometimes across multiple years retrospectively, and often based on actual claims paid. Until now, CalOptima has made these DHCS- and CMS- defined supplemental payments to its health networks via contract amendment, as notification came down from the state or federal government. Given the ongoing nature of these payments – including those given under Proposition 56 - multiple amendments, retroactive contract terms, and subsequent timeliness concerns for payment to the impacted providers have been ongoing concerns. To mitigate this, staff recommends that moving forward, Directed Payments be administered according Policy & Procedure FF. 2011 ("Directed Payments"), which addresses Directed Payment programs listed below. Directed Payment is an add-on payment or minimum fee payment required by DHCS to be made to eligible providers for qualifying services (identified below) with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments. As an alternative to requesting authority to amend these contracts on each individual occasion, Policy FF.2011 directs CalOptima to reimburse Health Networks for Direct Payments as they are mandated, pursuant to qualifying services being rendered, providing both policy and procedure guidelines.

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance
Physician Services	7/1/2017 to 12/31/2020	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
Ground Emergency Medical Transport (GEMT)*	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 APL 20-002 released January 31, 2020

**Directed Payments for GEMT Services are not applicable to Shared-Risk Group*

Staff anticipates that Policy FF.2011 will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Shared Risk Pool Revisions
Pursuant to a separate Board action, Staff has revised CalOptima Policy FF.1010: Shared Risk Pool to clarify language regarding the Shared Risk pool budget in relation to Coordination of Benefits (COB) recoveries. This revision clarifies that:

1) COB recoveries reduce expense but do not increase revenue; and

2) Since CalOptima is self-insured, reinsurance premium will no longer be allocated to the risk pool.

Fiscal Impact
The recommended actions to enter into amended Medi-Cal Health Network contracts to extend through June 30, 2021, add language reflecting changes to how the Directed Payments are handled, and align Shared Risk group contracts with revisions to CalOptima Policy FF.1010 are not expected to have a fiscal impact.

Costs associated with the recommended action to adjust capitation rates for these contracts, with the exception of Kaiser Foundation Health Plan, Inc., have been included in the proposed CalOptima Fiscal Year (FY) 2020-21 Operating Budget pending Board approval. These proposed changes represent an approximately 2.0% overall reduction in Medi-Cal Classic health network capitation payments, projected at an estimated $8 million in FY 2020-21. In addition, the budget proposes an overall reduction of 7% to the MCE Professional capitation rate and a reduction of 14% to the MCE Hospital capitation rate. Aggregate decreases to MCE Professional capitation expenses and associated shared risk pools are projected to be $50 million in FY 2020-21.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Contracted Entities Covered by this Recommended Action
2. Previous Board Action dated June 6, 2019, Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates
3. Previous Board Action dated December 6, 2018, Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole Child Model Implementation Date
4. Previous Board Action dated April 2, 2020, Consider Approval of CalOptima Medi-Cal Directed Payments Policy

5. Policy & Procedure FF.2011: Directed Payments
6. Policy & Procedure FF.1005f: Special Payments: Supplemental OB Delivery Care Payment
7. Previous Board Action dated March 7, 2013, Authorize and Direct Chief Executive Agreements with the California Department of Health Care Services (DHCS) and Kaiser Foundation Health Plan, (Kaiser)

/s/ Richard Sanchez *05/27/2020*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Kaiser Foundation Health Plan, Inc.	393 E Walnut St.	Pasadena	CA	91188
Heritage Provider Network, Inc.	8510 Balboa Blvd. Ste. 285	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West Ste. 800	Orange	CA	92868
CHOC Physicians Network and Children's Hospital of Orange County	1120 West La Veta Avenue Ste. 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming St. Ste. 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	17100 Euclid St.	Fountain Valley	CA	92708
AMVI Care Health Network	600 City Parkway West, Ste. 800	Orange	CA	92868
Orange County Physicians IPA Medical Group, Inc dba Noble Community Medical Associates, Inc.	10855 Business Center Dr. Ste. C	Cypress	CA	90630
Talbert Medical Group, P.C.	2175 Park Place	El Segundo	CA	90245
ARTA Western California, Inc.	2175 Park Place	El Segundo	CA	90245
United Care Medical Group, Inc.	600 City Parkway West	Orange	CA	92868
AltaMed Health Services Corporation	2040 Camfield Ave.	Los Angeles	CA	90040

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Authorizing Amended and Restated Medi-Cal Full Risk Health Network Contract for Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. to Incorporate Changes Related to Department of Health Care Services Regulatory Guidance and Amend Capitation Rates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into Amended and Restated Full Risk Health Network Contracts with Heritage Provider Network, Inc., Monarch Health Plan, Inc., and Prospect Health Plan, Inc. effective July 1, 2019 date that address the following:

a) Changes to reflect requirements as set forth in the California Department of Health Care Services (DHCS) All Plan Letter (APL) 19-001, Medi-Cal Managed Care Health Plan Guidance on Network Provider Status, as well as other relevant statutory, regulatory, and/or contractual requirements;
b) Amended capitation rates for assigned members effective July 1, 2019 to the extent authorized by the Board in a separate Board action;

Background/Discussion

On December 6, 2018, the Board authorized extension of CalOptima's Medi-Cal Health Network contracts to June 30, 2020. In the interim, there have been numerous initiatives, APLs, and other regulatory updates which necessitate the revision of contract terms. Additionally, the Health Network contracts have been amended numerous times over the years reflecting program, compensation and/or regulatory changes and these changes need to be incorporated in a master template contract. At this time, Staff requests authority to issue an amended and restated Health Network contract incorporating previously approved amendments, changes to address regulatory guidance and amended capitation rates.

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with Health Networks. On January 17, 2019, DHCS issued APL 19-001 that identified the provisions that must be included in network provider contracts to meet state and federal contracting requirements.

In addition to the changes to the contract terms reflected in APL 19-001, Staff has incorporated additional statutory, regulatory and contractual revisions which include, but are not limited to:

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emergency services notification requirements; Government Claims Act specifications; and, document and data submissions certification obligations.

The budget for Fiscal Year (FY) 2019-20 reflects a decrease in Medi-Cal Expansion (MCE) revenue and an increase in Medi-Cal classic. Capitation reimbursement levels paid by CalOptima to providers for the MCE population is higher than levels that are supported by cost and utilization data. This fact coupled with the reduction in revenue from DHCS has resulted in decreases to the MCE capitation rates for the Health Networks. For the Medi-Cal Classic population Staff recommends an increase to both Professional and Hospital capitation for Adult TANF and SPD members. The amended and restated contract reflects revised capitation rates effective July 1, 2019 to the extent authorized by the Board in a separate Board action.

Fiscal Impact

The recommended action to enter into amended and restated Medi-Cal Health Network contracts to comply with requirements in DHCS APL 19-001, and other relevant statutory, regulatory, and/or contractual requirements is not expected to have a fiscal impact.

Costs associated with the recommended action to revise capitation rates for these contracts have been included in the proposed CalOptima FY 2019-20 Operating Budget pending Board approval. The budget includes proposed increases of 4% to the Adult Temporary Assistance for Needy Families (TANF) and seniors and persons with disabilities (SPD) Professional capitation rates and 6% to the Adult TANF and SPD Hospital capitation rates. The increases total approximately $7.5 million in FY 2019-20.

In addition, the budget proposes a reduction of 8% to the MCE Professional capitation rate and a reduction of 21% to the MCE Hospital capitation rate. Aggregate decreases to MCE capitation expenses and associated shared risk pools are projected to be $95 million in FY 2019-20.

Rationale for Recommendation

CalOptima staff recommends these actions to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. All Plan Letter APL 19-001
3. Board Action Dated December 6, 2018, authorizing the extension of CalOptima Medi-Cal Health Network Contracts

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

5/29/2019 — **Date**

Contracted Entities Covered by this Recommended Board Action

Legal Name	Address	City	State	Zip code
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868

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

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: January 17, 2019

ALL PLAN LETTER 19-001

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL MANAGED CARE HEALTH PLAN GUIDANCE ON NETWORK PROVIDER STATUS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding how the Department of Health Care Services (DHCS) evaluates Network Provider status in order to promote consistency between federal regulations, Medi-Cal managed care contracts, state law, APLs, and similar instructions. It is the general intention of DHCS to apply this policy related to Network Provider contracting requirements in a standardized manner, to the extent appropriate, across relevant contexts, including MCP Network Provider and Subcontractor agreements, provider directory reporting, network adequacy certification, and directed payments pursuant to Title 42 of the Code of Federal Regulations (CFR) Section 438.6(c).[1]

BACKGROUND:
In May 2016, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule in the Federal Register applicable to Medicaid managed care programs (Final Rule).[2] The Final Rule did not eliminate or weaken any of the existing requirements found in the current Medi-Cal managed care contract, but rather updated the managed care regulations to include new and expanded requirements for MCP Subcontractors and separately defined Network Providers.[3] In implementing the Final Rule, DHCS submitted contract amendments to CMS to bring its existing provisions related to "Subcontracts" into compliance with the new and more stringent federal requirements.[4] As of now, and consistent with historical practice and Title 22 of the California Code of

[1] 42 CFR, Part 438 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=1e1bce051e31df7ab188a92eff8209bf&mc=true&node=pt42.4.438&rgn=div5
[2] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[3] See 42 CFR 438.2, "Definitions."
[4] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date the amendment is pending approval by CMS, and is anticipated to be finalized with minimal changes.

Managed Care Quality and Monitoring Division
1501 Capitol Avenue, P.O. Box 997413, MS 4410
Sacramento, CA 95899-7413
Phone (916) 449-5000 Fax (916) 449-5005
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Regulations (CCR) Section 53250,[5] DHCS is maintaining uniformity to the extent appropriate with respect to the requirements for all "Subcontracts," regardless of whether the agreement is between an MCP and an entity defined as a "Subcontractor" or "Network Provider" under 42 CFR Section 438.2.[6]

While the guidance in this APL on how DHCS will evaluate compliance is prospective, many of these obligations were imposed as of July 1, 2017, in accordance with the Final Rule.

Additional guidance on what constitutes an eligible Network Provider for directed payment programs is set forth on the DHCS Directed Payments web page.[7]

POLICY:

I. **Required Characteristics of Network Providers**
Effective on or after July 1, 2019, a Network Provider, as defined in 42 CFR Section 438.2 and the Medi-Cal managed care contract in Exhibit E, Attachment 1, Definitions, must:

1. Have an executed written Network Provider Agreement with the MCP or a Subcontractor of the MCP that meets all the requirements set forth in Attachment A of to this APL;
2. Be enrolled in accordance with APL 17-019,[8] the Medi-Cal Managed Care Provider Enrollment Frequently Asked Questions (FAQ) document, or any subsequent APL or FAQ update on the topic, unless enrollment is not required as specified by DHCS;
3. Be reported on the MCP's 274 file submitted to DHCS, for all applicable filings, in accordance with APL 16-019 or any subsequent APL on the topic and the most recent DHCS 274 Companion Guide; and

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[5] The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[6] The Medi-Cal managed care contract defines the term Subcontract to include both Subcontractors and Network Providers (as those terms are defined under 42 CFR Section 438.2), and all requirements listed in Paragraph B of Provision 14 of Exhibit A, Attachment 6 apply to Network Providers. A provider may maintain Network Provider status without an agreement directly with an MCP, if they are connected through a series of Subcontracts, so long as those Subcontracts also meet all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and Policy Letters (PLs), in particular, but not limited to, those requirements in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic). That chain of Subcontracts may include an entity that is also a Network Provider, who, as a result of taking on an administrative function of contracting for care (and not providing that care itself), also meets the definition of a "Subcontractor."
[7] The DHCS directed payment web page is available at: https://www.dhcs.ca.gov/services/Pages/DirectedPymts.aspx
[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

4. Be included on all network adequacy filings that occur within the effective dates of the written Network Provider Agreement, in accordance with APL 18-005, or any subsequent APL on the topic, following the execution of the agreement. This does not automatically require the provider to be listed on a provider directory, nor does it require the inclusion of a Network Provider on network adequacy filings if such inclusion would be inappropriate due to timing or other circumstances, as discussed in APL 18-005.

For contract/rating periods commencing on or after July 1, 2019, when DHCS references Network Providers in guidance, information, instruction, or communications, it will refer to providers who meet the criteria outlined in this APL, unless expressly noted otherwise. MCPs must use the guidance provided in this APL and the checklist provided in Attachment A to update current Network Provider Agreement boilerplates for compliance before submitting to DHCS for review and approval. Note that this APL, including its attachment, is not an exhaustive list of all MCP duties related to Network Providers, and it is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs.

A provider that does not meet the criteria for a Network Provider shall not be reported on the 274 file or as part of the MCP's network adequacy filings.

II. Written Network Provider Agreement Requirements

In order to ensure alignment with the DHCS criteria for Network Providers across applicable settings, all MCPs must ensure that their Network Provider Agreements comply with current and applicable Medi-Cal managed care contract requirements.

In accordance with the current Medi-Cal managed care contracts and 22 CCR Section 53250, all Network Provider Agreement boilerplates must be submitted to DHCS for review and approval before use. A checklist of the required elements for these agreements is included as Attachment A of this APL. Where an MCP's relationship with a Network Provider includes one or more sub-delegated entities or a hospital to hospital agreement, each Subcontractor agreement that links the MCP to the Network Provider must also comply with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable APLs and PLs, in particular, but not limited to, those in Exhibit A, Attachment 6, Provision 14 and APL 17-004 (or any subsequent APL on the topic).

III. DHCS Review and Approval of Network Provider Agreement Boilerplate Compliance

As stated above, MCPs are required to submit Network Provider Agreement boilerplates that have been updated in accordance with the requirements in this APL to DHCS for review and approval prior to use. MCPs are also responsible for complying with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and PLs, as they relate to Network Provider requirements and Network Provider Agreements.

MCPs will have 60 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for hospital providers and 120 days from the release date of this APL to submit updated Network Provider Agreement boilerplates for non-hospital providers to their DHCS contract manager.

The timing for DHCS to review these Network Provider Agreement boilerplates will follow the current 60-day review timing requirements as outlined in the Medi-Cal managed care contract under Exhibit E, Attachment 3, Duties of the State, DHCS Approval Process.

If an MCP has a timing issue that would require a Network Provider Agreement boilerplate to be approved for use by DHCS sooner than the 60-day review period would allow, the MCP must notify its DHCS Contract Manager to arrange an alternate timing agreement.

IV. Directed Payment Impacts

All MCPs must comply with the terms of all directed payments approved by CMS in accordance with 42 CFR Section 438.6(c), as documented in CMS-approved preprints, state law, and/or as implemented by DHCS through APL or other similar guidance. All such guidance is available at the DHCS Directed Payments web page. If a Network Provider Agreement does not meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments, the services provided under that agreement will not be eligible for directed payments for rating periods commencing on or after July 1, 2019. For pooled directed payments where DHCS retrospectively calculates final payments based on the actual reported utilization of eligible services, MCPs must continue to provide supplemental encounter/service-level data, in a manner and at times specified by DHCS. This information will aid in identifying the subset of services provided under a Network Provider Agreement that meet the Network Provider criteria set forth in this APL and/or in DHCS guidance regarding directed payments.

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 PLs. 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

Attachment(s)

ALL PLAN LETTER 19-001
Attachment A

Attachment A: Network Provider Agreement Boilerplate Checklist

This Attachment establishes a checklist for MCPs to use in connection with their development of Network Provider Agreement templates. It is not intended to alter or limit an MCP's statutory and/or contractual obligations, nor does it limit an MCP's oversight obligations. MCPs are responsible for complying with all applicable state and federal law and contract requirements as well as DHCS guidance, including all applicable All Plan Letters and Policy Letters.

Network Provider Agreements must contain:	
1	Specification of the services to be provided by the Network Provider. Citation: Managed Care Plan Contract (MCP Contract), Exhibit A, Attachment 6, Provision 14.B.1 and Title 22, CCR, Sections 53250(c)(1) and 53867.[1]
2	Specification that the Network Provider Agreement must be governed by and construed in accordance with all laws and applicable regulations governing the Contract between Contractor and DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.2 and Title 22, CCR, Sections 53250(c)(2) and 53867.
3	Specification that the Network Provider Agreement or its amendments will become effective only as set forth in Exhibit A, Attachment 6, Provision 13.C. Departmental Approval – Non-Federally Qualified HMOs, or 13.D, Departmental Approval – Federally Qualified HMOs. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.3 and Title 22, CCR, Sections 53250(c)(3) and 53867.
4	Specification of the term of the Network Provider Agreement, including beginning and ending dates, methods of extension, renegotiation, and termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.4 and Title 22, CCR, Sections 53250(c)(4) and 53867.
5	Language comparable to Exhibit A, Attachment 8, Provision 13. Contracting & Non-Contracting Emergency Service Providers & Post-Stabilization, for those Network Providers at risk for non-contracting emergency services. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.5.
6	Network Provider's agreement to submit reports as required by Contractor. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.6, Exhibit A, Attachment 3, Provision 2.C and 2.G, and Title 22, CCR, Sections 53250(c)(5) and 53867.

[1] Note that references to contract provisions in this document reflect changes made by the 2017 Final Rule amendment (identified as Package 42, an updated version of which was shared with MCPs in January 2018). To date, the amendment is pending approval by CMS and is anticipated to be finalized with minimal changes.

7	Specification that the Network Provider must comply with all monitoring provisions of the MCPs' contracts and any monitoring requests by DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.7, 42 CFR 438.3(h), and Title 22, CCR, Sections 53250(e)(1) and 53867.
8	Network Provider's agreement to make all of its premises, facilities, equipment, books, records, contracts, computer and other electronic systems pertaining to the goods and services furnished under the terms of the Network Provider Agreement, available for the purpose of an audit, inspection, evaluation, examination or copying, including but not limited to Access Requirements and State's Right to Monitor, as set forth in Exhibit E, Attachment 2, Provision 20. Inspection Rights: a) By DHCS, CMS, Department of Health and Human Services (DHHS) Inspector General, the Comptroller General, Department of Justice (DOJ), and Department of Managed Health Care (DMHC), or their designees. b) At all reasonable times at the Network Provider's place of business or at such other mutually agreeable location in California. c) In a form maintained in accordance with the general standards applicable to such book or record keeping. d) For a term of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. e) Including all Encounter Data for a period of at least ten (10) years. f) If DHCS, CMS, or the DHHS Inspector General determines there is a reasonable possibility of fraud or similar risk, DHCS, CMS, or the DHHS Inspector General may inspect, evaluate, and audit the Network Provider at any time. g) Upon resolution of a full investigation of fraud, DHCS reserves the right to suspend or terminate the Network Provider from participation in the Medi-Cal program; seek recovery of payments made to the Network Provider; impose other sanctions provided under the State Plan, and direct Contractor to terminate their Network Provider Agreement due to fraud. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.8, Exhibit E, Attachment 2, Provision 20, and 42 CFR 438.3(h).

9	Full disclosure of the method and amount of compensation or other consideration to be received by the Network Provider. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.9 and Title 22, CCR, Sections 53250(e)(2) and 53867.
10	Network Provider's agreement to maintain and make available to DHCS, upon request, copies of all sub-subcontracts and to ensure that all sub-subcontracts are in writing and require that the Network Provider: a) Make all premises, facilities, equipment, applicable books, records, contracts, computer, or other electronic systems related to this Contract, available at all reasonable times for audit, inspection, examination, or copying by DHCS, CMS, or the DHHS Inspector General, the Comptroller General, DOJ, and DMHC, or their designees. b) Retain such books and all records and documents for a term minimum of at least ten (10) years from the final date of the Contract period or from the date of completion of any audit, whichever is later. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.10.
11	Network Provider's agreement to assist Contractor in the transfer of care pursuant to Exhibit E, Attachment 2, Provision 14. Phase out Requirements, Subparagraph B in the event of contract termination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.11.
12	Network Provider's agreement to assist Contractor in the transfer of care in the event of sub-subcontract termination for any reason. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.12.
13	Network Provider's agreement to notify DHCS in the event the agreement with the Contractor is amended or terminated. Notice is considered given when properly addressed and deposited in the United States Postal Service as first-class registered mail, postage attached. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.13 and Title 22, CCR, Sections 53250(e)(4) and 53867.
14	Network Provider's agreement that assignment or delegation of the Network Provider Agreement or Subcontract will be void unless prior written approval is obtained from DHCS. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.14 and Title 22, CCR, Sections 53250(e)(5) and 53867.
15	Network Provider's agreement to hold harmless both the State and Members in the event Contractor cannot or will not pay for services performed by the Network Provider pursuant to the Network Provider Agreement. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.15 and Title 22, CCR, Sections 53250(e)(6) and 53867.

16	Network Provider's agreement to timely gather, preserve and provide to DHCS, any records in the Network Provider's possession, in accordance with Exhibit E, Attachment 2, Provision 24. Records Related to Recovery for Litigation. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.16.
17	Network Provider's agreement to provide interpreter services for Members at all Provider sites. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.17.
18	Network Provider's right to submit a grievance and Contractor's formal process to resolve Provider Grievances. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.18.
19	Network Provider's agreement to participate and cooperate in Contractor's Quality Improvement System. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.19.
20	If Contractor delegates Quality Improvement activities, the Network Provider Agreement must include those provisions stipulated in Exhibit A, Attachment 4, Provision 6. Delegation of Quality Improvement Activities. Contractor and delegated entity (Network Provider) must include in their Network Provider Agreement, at minimum: 1) Quality improvement responsibilities, and specific delegated functions and activities of the Contractor and Network Provider. 2) Contractor's oversight, monitoring, and evaluation processes and Network Provider's agreement to such processes. 3) Contractor's reporting requirements and approval processes. The agreement must include Network Provider's responsibility to report findings and actions taken as a result of the quality improvement activities at least quarterly. 4) Contractor's actions/remedies if Network Provider's obligations are not met. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.20 and Exhibit A, Attachment 4, Provision 6.A.
21	Network Provider's agreement to comply with all applicable requirements of the DHCS, Medi-Cal Managed Care Program. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.21.
22	Network Provider's agreement to revoke the delegation of activities or obligations, or specify other remedies in instances where DHCS or Contractor determine that the Network Provider has not performed satisfactorily. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.22, 42 CFR 438.230(c)(iii), and Title 22, CCR, Sections 53250 and 53867.

23	To the extent that the Network Provider is responsible for the coordination of care for Members, Contractor's agreement to share with the Network Provider any utilization data that DHCS has provided to Contractor, and the Network Provider's agreement to receive the utilization data provided and use it as the Network Provider is able for the purpose of Member care coordination. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.23 and 42 CFR 438.208.
24	Contractor's agreement to inform the Network Provider of prospective requirements added by DHCS to Contractor's Contract with DHCS before the requirement would be effective, and Network Provider's agreement to comply with the new requirements within 30 days of the effective date, unless otherwise instructed by DHCS and to the extent possible. Citation: MCP Contract, Exhibit A, Attachment 6, Provision 14.B.24.
25	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely provider data needed by Contractor in order for Contractor to meet its provider data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provision 1; APL 16-019, and any subsequent updates.
26	A provision requiring Network Providers to submit to Contractor complete, accurate, reasonable, and timely Encounter Data needed by Contractor in order for Contractor to meet its encounter data reporting requirements to DHCS. Citation: MCP Contract, Exhibit A, Attachment 3, Provisions 2.C and 2.G.; APL 14-019, and any subsequent updates.
27	A provision prohibiting Network Providers from balance billing a Medi-Cal member. Citation: MCP Contract, Exhibit A, Attachment 8, Provision 6.
28	A provision stating that Contractor will provide cultural competency, sensitivity, and diversity training. Citation: MCP Contract, Exhibit A, Attachment 9, Provision 13.E.
29	A provision confirming a Network Provider's right to access Contractor's dispute resolution mechanism. Citation: Health & Safety Code §1367 (h)(1).
30	A provision requiring that Network Providers comply with language assistance standards developed pursuant to Health & Safety Code §1367.04.
31	A provision confirming that Network Providers are entitled to all protections afforded them under the Health Care Providers' Bill of Rights. Citation: Health & Safety Code §1375.7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

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

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

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To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), 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 (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

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

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

Background

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

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

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

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

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

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

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

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

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

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

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

Discussion

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

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

Implementation Plan Elements

Delivery Model

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Candidates for the open positions are as follows:
Family Representatives

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

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

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

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

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

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

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

~~*CBO/Advocate Representatives*~~

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

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

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

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

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

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

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

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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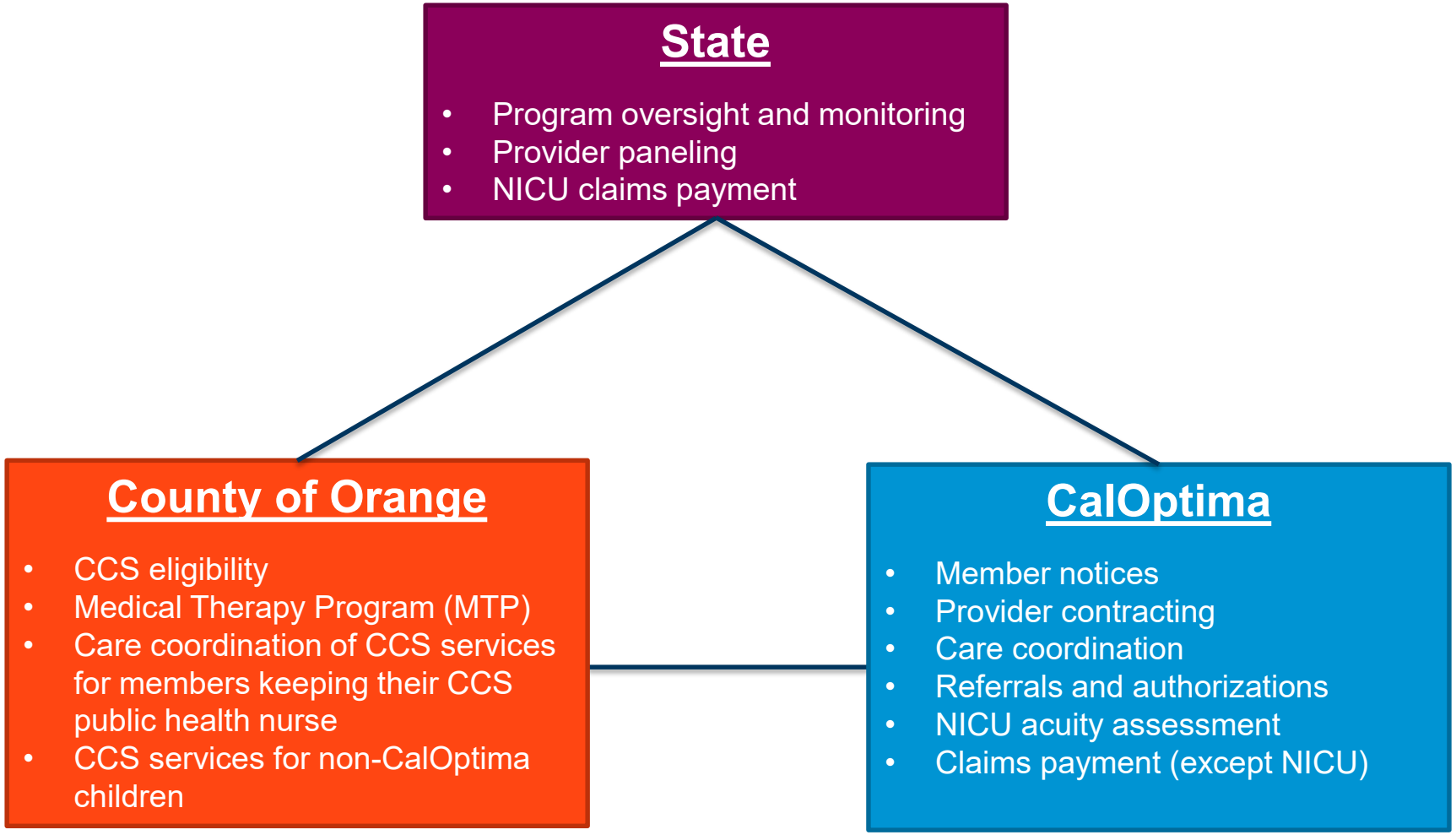
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - ➢ All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - ➢ Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD
MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

Rev. 11/2/2017

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 6, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Amendments to the Health Network Medi-Cal Contracts and Policies and Procedures to Align with the Anticipated Whole-Child Model Implementation Date

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into amendments of the Medi-Cal health network contracts, with the assistance of Legal Counsel, to:
    a. Postpone the payment of capitation for the Whole-Child Model (WCM) until the new program implementation date of July 1, 2019 or the Department of Health Care Services (DHCS)-approved commencement date of the CalOptima WCM program, whichever is later;
    b. Authorize the continued payment to fund the Personal Care Coordinators at existing levels for WCM members for the period January 1, 2019 - June 30, 2019;
    c. Extend the health network contracts to June 30, 2020, with CalOptima retaining the right to implement rate changes, whether upward or downward, based on rate changes implemented by the State; and
2. Authorize modification of existing WCM-related Policies and Procedures to be consistent with the DHCS-approved commencement date of the CalOptima WCM program.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill (SB) 586 into law, which authorizes the California Department of Health Care Services (DHCS) to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the WCM program. WCM's goals include improving coordination and integration of services to meet the needs of the whole child, retaining CCS program standards, supporting active family participation, and maintaining member-provider relationships, where possible.

DHCS is implementing the WCM program on a phased-in basis, with implementation for Orange County originally scheduled to begin no sooner than January 1, 2019. On that date, CalOptima was to assume financial responsibility for the authorization and payment of CCS-eligible medical services, including service authorizations activities, claims management (with some exceptions), case management, and quality oversight.

To that end, CalOptima has been working with the DHCS to define and meet the requirements of implementation. Of importance to the DHCS, is the sufficiency of the contracted CCS-paneled providers to serve members with CCS-eligible conditions and the assurance that all members have access to these providers. On November 9, the State notified CalOptima that the transition of the Whole-Child Model in Orange County will be delayed until DHCS approved commencement date of the CalOptima WCM program, currently anticipated for July 1, 2019.

The State has determined that additional time is needed to plan the transition of the CCS membership due to the large number of members with CCS eligible conditions and the complexities associated the delegated delivery model. With nearly 13,000 members with CCS eligible conditions, CalOptima has the largest membership transitioning to WCM.

The health network contracts currently expire on June 30, 2019, which is prior to the currently targeted implementation date for the WCM. These contracts are typically extended on a year-to-year basis after the Board has approved an extension. The health networks each sign amendments reflecting any new terms and conditions. The currently anticipated July 1, 2019 effective date coincides with the start of the State's fiscal year and the amendment includes modification to capitation rates, if applicable, based on changes from DHCS, and any regulatory and other changes as necessary. The State typically provides rates to CalOptima in April or May, which is close to the start of the next fiscal year. The timing has made it difficult to analyze, present, vet and receive signed amendments from health networks prior to the beginning of the next year.

Discussion

In anticipation of the original January 1, 2019 WCM program implementation, staff issued health network amendments specifying the terms of participation in the WCM program. The amendment includes CalOptima's responsibility to pay WCM capitation rates effective January 1, 2019. With the delay in implementation of the WCM for six months, staff requests authority to amend the health network contracts such that the obligation to pay capitation rates for WCM services will take effect with the new anticipated commencement date to be approved by the state, currently anticipated to be July 1, 2019. WCM related policy and procedures will also be updated to reflect the new implementation date.

In addition, the Board authorized the funding the health networks for Personal Care Coordinators (PCC) for members with CCS eligible conditions. The payment for the PCCs began in October 2018 to the health networks to hire and train coordinators prior to the then anticipated program implementation date of January 1, 2019. Most of the health networks have hired the coordinators in anticipation of the original effective date. Because the late notification of the delay in the WCM start date in Orange County, and the health networks commitment to hire staff, staff recommends that the funding be continued at the prescribed level until the beginning of the program. At that time, the funding will be adjusted, to reflect the quality of the services provided by the health networks.

As noted above, health network contracts currently are set to terminate on June 30, 2019, which is prior to the anticipated commencement date of the CalOptima WCM program. In order to obtain health network commitment to the WCM program and allow the networks to adequately review and comment

on any changes to the contracts for the next fiscal year, staff is asking for authority to extend the contracts through June 30, 2020. Staff also requests the authority to amend the health network contracts to adjust capitation rates retroactively to the DHCS-approved commencement date of the CalOptima WCM program once the State rates have been received and analyzed.

Fiscal Impact

The Fiscal Year (FY) 2018-19 Operating Budget approved by the Board on June 7, 2018, included revenues, medical expenses and administrative expenses with an anticipated implementation date of January 1, 2019. Due to the delayed implementation date, WCM program revenues and expenses, with the exception of start-up and PCC costs, are currently expected to begin on July 1, 2019. Therefore, the recommended action to postpone the capitation payments for the WCM program until the new implementation date of July 1, 2019, is expected to be budget neutral.

The fiscal impact of payments to PCCs at existing levels for WCM members for the period of January 1, 2019, through June 30, 2019, is projected at $672,000. Management anticipates that the fiscal impact of the total start-up and PCC costs related to the WCM program through June 30, 2019, are budgeted and will have no additional fiscal impact to the Medi-Cal operating budget.

The recommended action to extend health network contracts to June 30, 2020, is budget neutral for the remainder of FY 2018-19. Management will include any associated expenses related to the contract extensions in the FY 2019-20 Operating Budget.

Rationale for Recommendation

The recommended action will clarify and facilitate the implementation of the Whole Child Model effective upon the DHCS-approved commencement date of the CalOptima WCM program, currently anticipated to be July 1, 2019. This will also allow the health networks adequate time to review and analyze any changes to the contract which may be required.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated August 2, 2018, Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium for AMVI Care Health Network, Family Choice Network and Fountain Valley Regional Medical Center
2. Contracted Entities Covered by this Recommended Action

/s/ Michael Schrader — *11/28/2018*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 2, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), 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 (WCM); and
4. Extend contracts through June 30, 2019.

Background

CalOptima pays its health networks according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which the rates are based, was developed by consultant Milliman Inc. utilizing encounter and claims data. CalOptima periodically increases or decreases the capitation rates to account for increases or decreases in capitation rates from the Department of Health Care Services (DHCS) or to account for additional services to be provided by the health networks. An example of this is the recent capitation rate change to account for the transition of the payment of Child Health Disability Program (CHDP) services from CalOptima to the health networks.

It is incumbent on CalOptima to periodically review the actuarial cost model to ensure that the rate methodology, and the resulting capitation rates, continue to allocate fiscal resources commensurate with the level of medical needs of the populations served. This review and adjustment of capitation rates is referred to as rebasing. Staff has worked with Milliman Inc. to develop a standardized rebasing methodology that was previously adopted and approved by CalOptima and the provider community.

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed

Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal Managed Care Plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include: improving coordination and integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and maintaining member-provider relationships where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. At the June 7, 2018 Board meeting, staff received authority to proceed with several actions related to the WCM program including carving CCS services into the health network contract.

At the June 7, 2018 Board meeting, the Board of Directors authorized the extension of the health network contracts through December 31, 2018. The six-month extension, as opposed to the normal one-year extension, was made to allow staff to review, adjust and vet capitation rates and requirements associated with the transition of the CCS program from the State and County to CalOptima and the complete the capitation rate rebasing initiative. Both of these program changes are effective January 1, 2019.

Discussion

Rebasing: CalOptima last performed a comprehensive rate rebasing in 2009. The goal of rebasing is to develop actuarially sound capitation rates that properly aligns capitation payments to a provider's delegated risks. To ensure that providers are accurately and sufficiently compensated, rebasing should be performed on a periodic basis to account for any material changes to medical costs and utilization patterns. To that end, staff has been working with Milliman Inc. to analyze claims utilization data and establish updated capitation rates that reflect more current experience. As proposed, only professional and hospital capitation rates for the Medi-Cal Classic population are being updated through this rebasing effort. Staff requests authority to amend the health network contracts to reflect the new rebased capitation rates effective January 1, 2019.

WCM: To ensure adequate revenue is provided to support the WCM program, CalOptima will develop actuarially sound capitation rates that are consistent with the projected risks that will be delegated to capitated health networks and hospitals. CalOptima also recognizes that medical costs for CCS members can be highly variable and volatile, possibly resulting in material cost differences between different periods and among different providers. To mitigate these financial risks and ensure that networks will receive sufficient and timely compensation, management proposes that CalOptima implement two retrospective reimbursement mechanisms: (1) Interim reimbursement for catastrophic cases; and (2) Retrospective risk corridor.

WCM incorporates requirements from SB 586 and CCS into Medi-Cal Managed Care. Many of these WCM requirements will include new requirements for the health networks. Included is the requirement that the health networks will be required to use CCS paneled providers and facilities to treat children and youth for their CCS condition. Continuity of care provisions and minimum provider rate requirements (unless provider has agreed to different rates with health network) are also among the health network requirements.

Staff requests authority to incorporate the WCM rates and requirements into the health network contracts.

Extension of the Contract Term. Staff requests authority to amend the Medi-Cal contracts to extend the contracts through June 30, 2019.

Fiscal Impact

The recommended action to modify capitation rates, effective January 1, 2019, associated with rebasing is projected to be budget neutral to CalOptima. The rebased capitation rates are not projected to materially change CalOptima's aggregate capitation expenses. Management has included expenses associated with rebased capitation rates in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018.

The recommended action to amend health network contracts, effective January 1, 2019, to include rates associated with the WCM program is a budgeted item. Management has included projected revenues and expenses associated with the WCM program in the CalOptima FY 2018-19 Operating Budget approved by the Board on June 7, 2018. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual WCM program costs at approximately $274 million. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be highly volatile. CalOptima staff will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in rates and responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Contracted Entities Covered by this Recommended Board Action
2. Board Action dated June 7, 2018, Consider Actions Related to CalOptima's Whole-Child Model Program
3. Board Action dated June 4, 2009, Approve Health Network Contract Rate Methodology

4. Board Action dated December 17, 2003, Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

/s/ Michael Schrader — *7/25/2018*

Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

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        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background

The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

1. ~~Michael Arnot for a two-year term ending June 30, 2020;~~
2. ~~Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
3. ~~Gabriela Huerta for a two-year term ending June 30, 2020; and~~
4. ~~Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

/s/ Michael Schrader — **Authorized Signature**

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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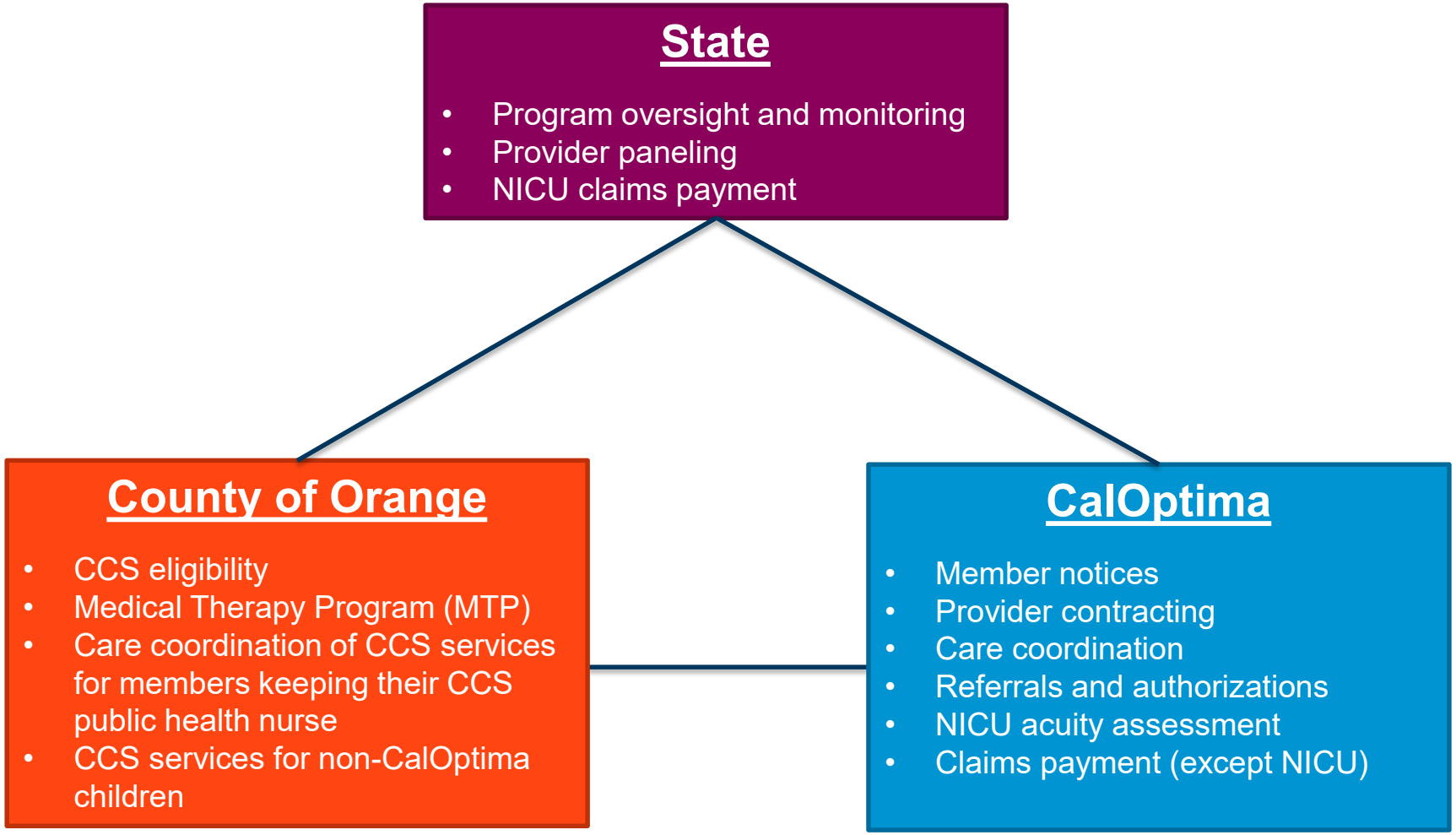
Background

Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - ➢ All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - ➢ Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 2, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev. 11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader — **Authorized Signature**

10/23/2017 — **Date**

RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD
MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CalOptima Board Action Agenda Referral

Action To Be Taken June 4, 2009
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Health Network Contract Rate Methodology

Contact
Michael Engelhard, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve the modification methodology of Health Network capitation rates for October 1, 2009.

Background
Health Network capitation is the payment method that CalOptima uses to reimburse PHCs and shared risk groups for the provision of health care services to members enrolled in CalOptima Medi-Cal and CalOptima Kids. In order to ensure that reimbursement to such capitated providers reflects up-to-date information, CalOptima periodically contracts with its actuarial consultants to recalculate or "rebase" these payment rates.

The purpose of this year's rebasing is to:

- Establish actuarially sound facility and professional capitation rates;
- Account for changes in CalOptima's delivery model;
- Incorporate changes in the Division of Financial Responsibility (DOFR); and
- Perform separate analyses for Medi-Cal and CalOptima Kids.

The overall methodology for this year's rebasing approach includes:

- CalOptima eligibility data;
- Encounter and CalOptima Direct (COD) claim data analysis
- Reimbursement analysis;
- PCP capitation analysis;
- Maternity "kick" payment analysis;
- State benefit carve-out analysis;
- Reinsurance analysis;
- Administrative load analysis;
- Budget neutrality established

Discussion
CalOptima uses capitation as one way to reimburse certain contracted health care providers for services rendered. A Capitation payment is made to the provider during the month and is based solely on the number of contracted members assigned to that provider

at the beginning of each month. The provider is then responsible for utilizing those dollars in exchange for all services provided during that month or period.

To ensure that capitated payment rates reflect the current structure and responsibilities between CalOptima and its delegated providers, capitation rates need to be periodically reset or rebased.

CalOptima last performed a comprehensive rate rebasing in July 2007, for rates effective January 1, 2008, for CalOptima Medi-Cal only. Much has changed since that time including the establishment of shared risk groups; the movement of certain high-acuity members out of the Health Networks and into COD; changes in the DOFR between hospitals, physicians and CalOptima; shifts in member mix between the Health Networks; and changes in utilization of services by members.

Therefore, CalOptima opted to perform another comprehensive rebasing analysis prior to the FY2009-10 year in order to fully reflect the above-mentioned changes.

Fiscal Impact
CalOptima projects no fiscal impact as a result of the rebasing. Rebasing is designed to be budget neutral to overall CalOptima medical expenses even though there will likely be changes to specific capitation rates paid to Health Network providers.

Rationale for Recommendation
Staff recommends approval of this action to provide proper reimbursement levels to CalOptima's capitated health networks participating in CalOptima Medi-Cal and CalOptima Kids.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *5/27/2009*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 17, 2003
Special Meeting of the CalOptima Board of Directors

Report Item
VI. A. Approve Modifications to the CalOptima Health Network Capitation Methodology and Rate Allocations

Contact
Amy Park, Chief Financial Officer, (714) 246-8400

Recommended Action
Approve modifications to the CalOptima health network capitation methodology and rate allocations between Physician and Hospital financial responsibilities effective March 2004.

Background
CalOptima pays its health networks (HMOs and PHCs) according to the same schedule of capitation rates, which are adjusted by Medi-Cal aid category, gender and age. The actuarial cost model, upon which these rates are based, was developed by Milliman USA utilizing pre-CalOptima Orange County fee-for-service (FFS) experience as the baseline. This model then took into account utilization targets that were actuarially-appropriate for major categories of services and competitive reimbursement levels to ensure sufficient funds to provide all medically necessary services under a managed care model.

Since development of the model in 1999, CalOptima has negotiated capitation rate increases from the State for managed care rate "pass throughs" as a result of provider rate increases implemented in the Medi-Cal FFS program. In turn, CalOptima passed on these additional revenues to the health networks by increasing capitation payments, establishing carve-outs (e.g., transplants), or offering additional financial support, such as funding for enhanced subspecialty coverage and improving reinsurance coverage.

It has now been over four years since CalOptima commissioned a complete review of the actuarial cost model. As noted, CalOptima has only adjusted the underlying pricing in the actuarial cost model over the years to pass on increases in capitation rates to the health networks.

In light of State fiscal challenges and impending potential Medi-Cal funding and benefit reductions, CalOptima must examine the actuarial soundness of the existing cost model and update the utilization assumptions to ensure that CalOptima's health network capitation rate methodology continues to allocate fiscal resources commensurate with the level of medical needs of the population served. This process will also provide

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CalOptima with a renewed starting point from which to make informed decisions as we face yet another round of State budget uncertainties and declining resources.

Discussion

General Process. With the updated model, Milliman's rebasing process takes into account the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. Milliman examined the utilization statistics as indicated by the health network encounter data and evaluated the utilization for completeness by comparing against health network reported utilization and financial trends, health network primary care physician capitation and other capitation rates, health network hospital risk pool settlements, and other benchmarks as available. Further adjustments were made to account for changes in contractual requirements in the 2003-2005 health network contracts.

Utilization Assumptions. Consistent with changes in the State rate methodology, the updated health network capitation model combines the Family, Poverty and Child aid categories into a single Family aid category, with updated age/gender factors. The new model also recommends the creation of a supplemental capitation rate for members with end stage renal disease (ESRD). Furthermore, the actuarial model identifies actuarially-appropriate utilization targets for all major categories of services. These targets are set at levels that ensure that health networks have sufficient funds to provide all medically necessary services.

Pricing Assumptions. The new actuarial cost model includes reimbursement assumptions that are applied to the utilization targets to determine capitation rates. Effective October 2003, the State reduced CalOptima's capitation rates, effectively passing through the 5% cutback in physician and other provider rates as enacted in the 2003-04 State Budget Act. Notwithstanding this reduction, it is CalOptima's goal to maintain physician reimbursement levels to ensure members' continued access to care. Hence, CalOptima's health network minimum provider reimbursement policy and capitation funding will be maintained at its current levels. In other words, health networks will continue to be required to reimburse specialty physicians at rates that are no less than 150% of the Medi-Cal Fee Schedule and physician services in the actuarial model will continued to be priced at 147% of the August 1999 Medi-Cal Fee Schedule (as adjusted to primarily reflect market primary care physician capitation rates).

The actuarial cost model also provides sufficient funds to reimburse inpatient hospital reimbursement services at rates that are comparable to the average Southern California per diem rates and payment trends as published by California Medical Assistance Commission (CMAC) and to reimburse hospital outpatient services, commensurate with physician services, at 147% of the August 1999 Medi-Cal Fee Schedule.

In addition, the actuarial cost model provides sufficient funds for health network administrative expenses and an allowance for surplus. The table below summarizes the adjusted allocation of health network capitation rates to reflect the new actuarial cost model:

Aid Category	Proposed Hospital	Proposed Physician	Proposed Combined
Family/Poverty/Child	-4.6%	2.1%	-0.7%
Adult	-19.4%	-3.1%	-12.0%
Aged	18.9%	19.1%	19.0%
Disabled	10.9%	-4.4%	3.3%
Composite	1.7%	0.7%	1.2%

**Percentage changes are calculated from current capitation rates which have been adjusted to reflect the establishment of a separate ESRD supplemental capitation.*

Fiscal Impact

In summary, the proposed modifications will increase capitation payments made to physicians by 0.7%, while capitation payments to hospitals will increase by approximately 1.7%, for an overall weighted average increase in health network capitation rate payments of 1.2%, or $3.1 million on an annualized basis.

This additional increase will be funded by the Medi-Cal capitation rate increases received by CalOptima related to the State's settlement of the *Orthopaedic v. Belshe* lawsuit concerning Medi-Cal payment rates for hospital outpatient services.

As the Board will recall, the additional monies received by CalOptima related to this hospital outpatient settlement were passed through to hospitals in a lump-sum payment as approved by the Board in April 2003 for Fiscal 2001-02. That Board action also included approval for a second distribution scheduled for January 2004 to be made to hospitals for Fiscal 2002-03 related monies. Therefore, the proposed increases in hospital capitation rates contained in this action referral will facilitate the ongoing distributions of these dollars to CalOptima's participating hospitals. *See also related Board action referral to approve modifications to CalOptima Direct hospital reimbursement rates.*

Rationale for Recommendation

The proposed modifications to the rate methodology and related allocation of funds are consistent with the extensive, independent analysis performed by Milliman USA to update CalOptima's health network capitation methodology to reflect the 7+ years of health network managed care experience, rather than the historical pre-CalOptima Orange County FFS experience, as a base for capitation rates. The updated actuarial model also provides CalOptima with a renewed starting point from which to make informed

decisions as we face yet another round of State budget uncertainties and declining resources.

Concurrence
CalOptima Board of Directors' Finance Committee

Attachments
None

/s/ Mary K. Dewane — *12/9/2003*
Authorized Signature — **Date**

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
AltaMed Health Services Corporation	2040 Camfield Avenue	Los Angeles	CA	90040
AMVI Care Health Network	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group ARTA Western California, Inc.	3390 Harbor Blvd.	Costa Mesa	CA	92626
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	7631 Wyoming Street, Suite 202	Westminster	CA	92683
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Monarch Health Plan, Inc.	11 Technology Drive	Irvine	CA	92618
Orange County Physicians IPA Medical Group, Inc. dba Noble Community Medical Associates, Inc. of Mid-Orange County	5785 Corporate Ave	Cypress	CA	90630
Prospect Health Plan, Inc.	600 City Parkway West, Suite 800	Orange	CA	92868
DaVita Medical Group Talbert California, P.C.	3390 Harbor Blvd.	Costa Mesa	CA	92626
United Care Medical Group, Inc.	600 City Parkway West, Suite 400	Orange	CA	92868
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Kaiser Foundation Health Plan, Inc.	393 Walnut St.	Pasadena	CA	91188

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Approval of CalOptima Medi-Cal Directed Payments Policy

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Nancy Huang, Chief Financial Officer, (714) 246-8400

Recommended Actions

That the Board of Directors:

1. Approve CalOptima Medi-Cal Policy FF.2011 Directed Payments to align with current operational processes and comply with the Department of Health Care Services (DHCS) Directed Payment programs guidance.

2. Authorize the advance funding of the Directed Payments, as necessary and appropriate, for the Directed Payment programs identified in CalOptima Policy FF.2011.

3. Authorize the Chief Executive Officer, to approve as necessary and appropriate, the continuation of payment of Directed Payments to eligible providers for qualifying services before the release of DHCS final guidance, if instructed, in writing, by DHCS, and the State Plan Amendment (SPA) has been filed with the Centers for Medicare & Medicaid Services (CMS) for an extension of the Directed Payment program identified in CalOptima Policy FF.2011.

4. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to update and amend, as necessary and appropriate, Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima.

Background/Discussion

DHCS has implemented Directed Payment programs aimed at specified expenditures for existing health care services through different funding mechanisms. The current DHCS Directed Payments programs are funded by the Quality Assurance Fee (QAF) and Proposition 56. DHCS operationalizes these Directed Payments programs by either adjusting the existing Medi-Cal fee Schedule by establishing a minimum fee schedule payment or through a specific add-on (supplemental) payment administered by the Medi-Cal Managed Care Plans (MCPs). DHCS releases Directed Payments guidance to the MCPs through All Plan Letters (APLs). The APLs include guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

CalOptima has established processes to meet regulatory timeliness and payment requirements for Proposition 56 physician payments and GEMT for the delegated health networks. On June 7, 2018 the CalOptima Board of Directors (Board) approved the methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers and services rendered for dates of service (DOS) in SFY 2017-18. On June 6, 2019, the Board ratified implementation of the standardized annual

Proposition 56 provider payment process for physician services extended into future DOS. On September 5, 2019, the Board approved the implementation of the statutorily mandated rate increase for GEMT. While staff initially planned for these initial directed payment initiatives to be time limited, additional directed payment provisions are anticipated and expected to be on-going. DHCS has also released information for additional Directed Payments programs to be implemented. The existing and new Directed Payment programs are as follows:

Program Name	Effective DOS	Eligible Providers	Final DHCS Guidance as of December 26, 2019
Physician Services	7/1/2017 to 12/31/2021	Contracted	APL 18-010 released 05/01/2018 APL 19-006 released 06/13/2019 APL 19-015 released 12/24/2019
Abortion Services (Hyde)	7/1/2017 to 6/30/2020	All Providers	APL 19-013 released 10/17/2019
Developmental Screening Services	On or after 1/1/2020	Contracted	APL 19-016 released 12/26/2019
ACE (Trauma) Screening Services	On or after 1/1/2020	Contracted	APL 19-018 released 12/26/2019
GEMT	7/1/2018 to 6/30/2019	Non-Contracted	APL 19-007 released 6/14/2019 State Plan Amendment: 19-0020 released 09/06/2019 APL 20-002 released January 31, 2020

In order to meet timeliness and payment requirements, CalOptima staff recommends establishing Medi-Cal policy FF.2011 Directed Payments, which addresses the above-listed qualifying services. This new policy defines Directed Payments and outlines the process by which a Health Network will follow DHCS guidelines regarding qualifying services, eligible providers, and payment requirements for applicable DOS. The policy establishes new reimbursement processes for Directed Payments not included in the Health Network capitation and reimbursed to the Health Network on a per service basis as well as a 2% administrative fee component. In addition, the policy provides an initial monthly payment to the Health Network for estimated medical costs that will be reconciled with the monthly reimbursement reports. This process will apply to qualifying services and eligible providers as prescribed through an APL or specified by DHCS through other correspondence.

Staff seeks authority to update and amend Health Network Contracts and Attachment A: Directed Payments Rates and Codes of CalOptima Policy FF.2011, pursuant to DHCS final guidance or written instruction to CalOptima. In the future, staff also anticipates that this policy will need to be updated periodically, subject to Board approval, as new Directed Payment programs are issued by DHCS.

Staff seeks authority to implement funding for Directed Payment programs identified in CalOptima Policy FF.2011 before it receives funding from DHCS. As of March 2020, CalOptima has not received funding from DHCS for the new Proposition 56 programs for developmental screening services and adverse childhood experiences (ACE) screening services, as well as the existing Directed Payment

program for GEMT services for SFY 2019-20 which includes two (2) new CPT codes. Implementation of directed payments before DHCS has issued funding are necessary as DHCS final APLs have already been issued.

Operational policies for CalOptima Direct, including the CalOptima Community Network, will be modified separately. CalOptima staff will seek CalOptima Board of Directors (Board) ratification action as required.

Fiscal Impact

The recommended action to approve CalOptima Policy FF.2011 are projected to be budget neutral to CalOptima. Staff anticipates funding provided by DHCS will be sufficient to cover the costs related to Directed Payment programs. As DHCS releases additional guidance and performs payment reconciliation, including application of risk corridors, Staff will closely monitor the potential fiscal impact to CalOptima.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with regulatory guidance provided by DHCS.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Board Action
2. CalOptima Policy FF.2011: Directed Payments [Medi-Cal]
3. Board Action dated June 7, 2018, Consider Actions for the Implementation of Proposition 56 Provider Payment
4. Board Action dated June 6, 2019, Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process
5. Board Action dated September 5, 2019, Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

/s/ Michael Schrader *03/26/2020*
Authorized Signature **Date**

Policy:	FF.2011
Title:	Directed Payments
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.*, based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

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7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any

administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

   a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

   b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

   a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

   a. The following Developmental Screening Services are eligible for an Add-On Payment:

      i. A routine screening when provided:

         1) On or before the first birthday;

         2) After the first birthday and before or on the second birthday; or

3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.*, between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall

ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

   a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

   b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

   a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

      i. The Member has other sources of health coverage;

      ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

      iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

      iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

   a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

   a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

   b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.*, Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose 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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Attachment A: Directed Payments Rates and Codes

Proposition 56: Physician Services

1) **Program**: Proposition 56 Physician Services
2) **Source**: DHCS APL 19-015: Proposition 56 Directed Payments for Physician Services (*Supersedes APL 19-006*)
3) **Dates of Service (DOS)**: July 1, 2017 – December 31, 2021

CPT Code	Description	Add-On Payment		
		SFY 17-18	SFY 18-19	7/1/19-12/31/21
99201	Office/Outpatient Visit New	$10.00	$18.00	$18.00
99202	Office/Outpatient Visit New	$15.00	$35.00	$35.00
99203	Office/Outpatient Visit New	$25.00	$43.00	$43.00
99204	Office/Outpatient Visit New	$25.00	$83.00	$83.00
99205	Office/Outpatient Visit New	$50.00	$107.00	$107.00
99211	Office/Outpatient Visit Est	$10.00	$10.00	$10.00
99212	Office/Outpatient Visit Est	$15.00	$23.00	$23.00
99213	Office/Outpatient Visit Est	$15.00	$44.00	$44.00
99214	Office/Outpatient Visit Est	$25.00	$62.00	$62.00
99215	Office/Outpatient Visit Est	$25.00	$76.00	$76.00
90791	Psychiatric Diagnostic Eval	$35.00	$35.00	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00	$35.00	$35.00
90863	Pharmacologic Management	$5.00	$5.00	$5.00
99381	Initial Comprehensive Preventive Med E&M (<1 year old)	N/A	$77.00	$77.00
99382	Initial comprehensive preventive med E&M (1-4 years old)	N/A	$80.00	$80.00
99383	Initial comprehensive preventive med E&M (5-11 years old)	N/A	$77.00	$77.00
99384	Initial comprehensive preventive med E&M (12-17 years old)	N/A	$83.00	$83.00
99385	Initial comprehensive preventive med E&M (18-39 years old)	N/A	$30.00	$30.00
99391	Periodic comprehensive preventive med E&M (<1 year old)	N/A	$75.00	$75.00
99392	Periodic comprehensive preventive med E&M (1-4 years old)	N/A	$79.00	$79.00
99393	Periodic comprehensive preventive med E&M (5-11 years old)	N/A	$72.00	$72.00
99394	Periodic comprehensive preventive med E&M (12-17 years old)	N/A	$72.00	$72.00
99395	Periodic comprehensive preventive med E&M (18-39 years old)	N/A	$27.00	$27.00

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Developmental Screening Services

1) **Program**: Proposition 56 Developmental Screening Services
2) **Source**: DHCS APL 19-016: Proposition 56 Directed Payments for Developmental Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

CPT Code	Description	Add-On Payment[1]
96110 without modifier KX	Developmental screening, with scoring and documentation, per standardized instrument[2]	$59.90

[1]KX modifier denotes screening for Autism Spectrum Disorder (ASD). Add-On Payments for Developmental Screening Services are not payable for ASD Screening using modifier KX.

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Adverse Childhood Experiences (ACEs) Screening Services

1) **Program**: Proposition 56 Adverse Childhood Experiences (ACEs) Screening Services
2) **Source**: DHCS APL 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
3) **Dates of Service (DOS)**: On or after January 1, 2020

HCPCS Code	Description	Minimum Fee Payment[2]	Notes
G9919	Screening performed – results positive and provision of recommendations provided	$29.00	Providers must bill this HCPCS code when the patient's ACE score is 4 or greater (high risk).
G9920	Screening performed – results negative	$29.00	Providers must bill this HCPCS code when the patient's ACE score is between 0 – 3 (lower risk).

[2]*Payment obligations for rates of at least $29 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Proposition 56: Abortion Services (Hyde)

1) **Program**: Proposition 56 Abortion Services (Hyde)
2) **Source**: DHCS APL 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
3) **Dates of Service (DOS)**: On or after July 1, 2017

CPT Code	Procedure Type	Description	Minimum Fee Payment[3]
59840	K	Induced abortion, by dilation and curettage	$400.00
59840	O	Induced abortion, by dilation and curettage	$400.00
59841	K	Induced abortion, by dilation and evacuation	$700.00
59841	O	Induced abortion, by dilation and evacuation	$700.00

[3]*Payment obligations for rates of at least $400 and $700 for eligible service codes*

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

Ground Emergency Medical Transport (GEMT) Services

1) **Program**: Ground Emergency Medical Transportation (GEMT) Services
2) **Source**: State Plan Amendment 19-0020; DHCS APL 20-002: Non-Contract Ground Emergency Medical Transport Payment Obligations; and DHCS APL 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
3) **Dates of Service (DOS)**: On or after July 1, 2018 – June 30, 2020

CPT Code	Description	Minimum Fee Payment[4]	
		SFY 18-19	SFY 19-20
A0429	Basic Life Support, Emergency	$339.00	$339.00
A0427	Advanced Life Support, Level 1, Emergency	$339.00	$339.00
A0433	Advanced Life Support, Level 2	$339.00	$339.00
A0434	Specialty Care Transport	N/A	$339.00
A0225	Neonatal Emergency Transport	N/A	$400.72

[4]Payment obligations for rates of at least $339.00 and $400.72 for eligible service codes

Note: This communication is for reference only and is subject to future changes as directed by DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Consider Ratification of Standardized Annual Proposition 56 Provider Payment Process

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
Ratify standardized annual Proposition 56 provider payment process.

Background
Proposition 56 increases the excise tax rate on cigarettes and tobacco products to fund specified expenditures for existing health care programs administered by the Department of Health Care Services (DHCS). DHCS releases guidance to Medi-Cal managed care plans (MCP) of Proposition 56 provider payments through an All Plan Letter (APL). The APLs includes guidance regarding providers eligible for payment, service codes eligible for reimbursement, timeliness requirements to make payments, and MCP reporting requirements.

Eligible Proposition 56 provider payment adjustments are applied toward specific services provided during a State Fiscal Year (SFY), which runs from July 1 through June 30. While the payment period begins at the beginning of the SFY, final Proposition 56 guidance is not provided until after the fiscal year begins. For example, Proposition 56 guidance for SFY 2017-18 was received on May 1, 2018, ten months after the start of the fiscal year. Thus, MCPs are required to make a one-time retroactive payment adjustment to catch-up for dates of service (DOS) from the beginning of the SFY to the catch-up date. Once the initial catch-up payments are distributed, future payments are made within the timeframe specific in the APL.

On June 7, 2018 the CalOptima Board of Directors (Board) authorized implementation of initial payment and ongoing processing payments for Proposition 56 SFY 2017-18. In September 2018 DHCS instructed MCPs to continue Proposition 56 SFY 2017-18 provisions for DOS in SFY 2018-19, until SFY 2018-19 guidance was finalized. DHCS released draft Proposition 56 guidance for SFY 2018-19 on April 12, 2019. Final guidance has not been released as of May 28, 2019.

Discussion
In order to meet timeliness requirements for Proposition 56 payments each SFY and anticipating that requirements will continue to be released by APL or directly by DHCS, CalOptima staff recommends establishing a standardized annual process for Proposition 56 payment distributions. Ratification of this process is requested since CalOptima is required to distribute initial SFY 2018-19 Proposition 56 funds to providers no later than June 12, 2019, even though the final APL for the current fiscal year has not been released. The standardized process will apply to covered Medi-Cal Proposition 56 benefits administered directly by CalOptima (CalOptima Community Network or CalOptima Direct), or a

delegated health network. To comply with the annual Proposition requirements, CalOptima staff recommends utilizing the current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the receipt of initial payment from DHCS for the Proposition 56 designated SFY, CalOptima recommends an initial catch-up payment, if required, for eligible services between the beginning of the SFY to the current date, unless otherwise defined by DHCS. To process the initial catch-up payment, historical claims and encounter data will be utilized to identify the additional payments retroactively. Initial payments will be distributed no later than the timeliness requirements as defined in the APL. Similar to the previous process utilized, the following is recommended for each annual initial catch up payment:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims and encounters submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS.

- Health networks: Health network to utilize claims and encounter data to identify and appropriately pay providers retroactively for eligible services submitted for DOS beginning the SFY to the current date, unless otherwise defined by DHCS. CalOptima will prefund the health network for estimated medical costs. Health network will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the prefunded medical costs, negative and positive, will be reconciled towards future Proposition 56 reimbursements. In addition, a 2% administrative component based on total medical costs will be remitted to the health network.

Ongoing Processing

Once the initial payment is distributed, future Proposition 56 provider payments must be made within the timeframe as defined in the Proposition 56 APL for eligible clean claims or adjusted encounters. The following is recommended for ongoing processing provided that CalOptima continues to receive funding for Proposition 56:

- CalOptima Direct, which includes CalOptima Direct Administrative and CalOptima Community Network, and other providers paid directly by CalOptima for non-delegated Medi-Cal covered services (e.g., behavioral health providers): CalOptima will pay providers within the timeframe as defined by DHCS as claims or encounters are received.

- Health networks: Health network will pay providers within the timeframe defined by DHCS as claims or encounters are received. Concurrently, health network will be required to submit provider payment confirmation reports on a monthly basis that eligible Proposition 56 claims and encounter payments were issued timely. Reports will be due within 10 calendar days of the

end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component. Health networks will be required to report any recouped or refunded Proposition 56 payments received from providers. CalOptima will reconcile negative Proposition 56 medical and administrative payment adjustments towards future Proposition 56 reimbursements.

CalOptima, health networks will be expected to meet all reporting requirements as defined in the Proposition 56 APL or specifically requested by DHCS. Current processes will be used for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with all regulatory requirements and CalOptima's expectations related to Proposition 56. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as prescribed through a Proposition 56 APL or directed by DHCS. CalOptima staff will return to the Board for further approval if any future DHCS Proposition 56 requirements warrant significant changes to the proposed process. Additionally, should implementation of Proposition 56 require modifications to current health network, vendor, or provider contracts, CalOptima staff will seek separate Board action to the extent required.

Fiscal Impact
The recommended action to ratify the standardized annual Proposition 56 provider payment process is projected to be budget neutral to CalOptima. Based on historical claims experience, Staff anticipates medical expenditures will be of an equivalent amount as the Proposition 56 funding provided by DHCS annually, resulting in a budget neutral impact to CalOptima's operating income.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel
Board of Directors' Finance and Audit Committee

Attachment
June 7, 2018 CalOptima Board Action Agenda Referral Report Item 47. Consider Actions for the Implementation of Proposition 56 Provider Payment

/s/ Michael Schrader *5/29/2019*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 5, 2019
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Actions Related to the Implementation of Statutorily-Mandated Rate Increases for Medi-Cal Non-Contracted Ground Emergency Medical Transport (GEMT) Provider Services

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Approve payments to the capitated hospital(s) and HMOs for statutorily-mandated retrospective rate increases for specific services provided by non-contracted Ground Emergency Medical Transport providers to Medi-Cal members during the period of July 1, 2018 through June 30, 2019 and an administrative fee for claims adjustments; and
2. Direct the Chief Executive Officer, with the assistance of Legal Counsel, to amend the CalOptima Physician Hospital Consortium capitated Hospital and Full-Risk Health Network Medi-Cal contracts to incorporate the retrospective non-contracted Ground Emergency Medical Transport provider rate increase requirements for the July 1, 2018 through June 30, 2019 period and the additional compensation to these health networks for such services.

Background/Discussion

In accordance with Senate Bill (SB) 523 (Chapter 773, Statutes of 2017), the California Department of Health Care Services (DHCS) established increased Ground Emergency Medical Transport (GEMT) provider payments through the Quality Assurance Fee program for certain Medi-Cal related services rendered in State Fiscal Year (SFY) 2018-19. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare & Medicaid Services for GEMT provider payments through California State Plan Amendment 18-004. On April 5, 2019, CalOptima received initial funding for the retrospective non-contracted GEMT provider payment increase, separate from the standard capitation payment. Final guidance regarding distribution of non-contracted GEMT provider payments was released by DHCS through All Plan Letter (APL) 19-007, dated June 14, 2019.

Per DHCS guidance, CalOptima is required to provide increased reimbursement to out-of-network providers for GEMT service codes A0429 (Basic Life Support Emergency), A0427 (Advanced Life Support Emergency), and A0433 (Advanced Life Support, Level 2). CalOptima must reimburse out-of-network providers a total of $339 for each designated GEMT service provided by during SFY 2018-19 (July 1, 2018 to June 30, 2019). Excluded services include those billed by air ambulance providers and services billed when transport is not provided. DHCS has mandated that payments for the above increased rates are to be distributed no later than July 3, 2019.

At this time, the total reimbursement rate of $339 per identified service is time-limited and in effect for SFY 2018-19. Increased reimbursement for the specified GEMT services may potentially be extended into future fiscal years and may include additional GEMT transport codes. If the reimbursement

increase is extended, and/or includes additional GEMT transport codes, DHCS will provide further guidance after necessary federal approval is obtained.

In order to meet timeliness requirements for non-contracted GEMT provider payment adjustments for services provided during SFY 2018-19, CalOptima and its delegated health networks followed the existing Fee Schedule change process. Through this process, eligible claims previously adjudicated and paid were adjusted to the increased reimbursement rate. New claims are paid at the appropriate fee schedule as they are received.

For the physician-hospital consortium (PHC) hospitals and health maintenance organization (HMO) health networks that are financially responsible for non-contracted GEMT services, CalOptima staff recommends reimbursing the health networks the difference between the base Medi-Cal rate for the specific service and the required $339 enhanced rate. The health networks will be required to submit GEMT payment adjustment confirmation reports. Upon receipt of the confirmation report, CalOptima will reconcile the report against encounters and other claims reports received and reimburse each health network's medical costs, separate from their standard capitation payments, plus a 2% administrative component based on rate adjustments made by health networks.

CalOptima and its health networks will be expected to meet all reporting requirements as required by DHCS. Current processes will be leveraged for specific reporting requirements, provider grievances, and health network claims payment audit and oversight to comply with all regulatory requirements. Additionally, current policy and procedures will be followed related to provider payment recoupment, where applicable.

This process applies to eligible services and providers as directed by the DHCS. The same process will be leveraged should GEMT provisions be extended past SFY 2018-19, modified through an APL, or otherwise directed by DHCS. CalOptima staff will return to the Board for approval if any future DHCS non-contract GEMT provider payment requirements warrant significant changes to the proposed process.

Fiscal Impact

The recommended action to implement additional payment requirements for specified services provided by non-contracted GEMT providers to CalOptima Medi-Cal members in SFY 2018-19 is budget neutral. The anticipated Medi-Cal revenue is projected to be sufficient to cover the costs of the increased expense. Management included projected revenues and expenses related to non-contracted GEMT provider payment requirements in the CalOptima Fiscal Year 2019-20 Operating Budget approved by the Board on June 6, 2019.

Rationale for Recommendation

The recommended action will enable CalOptima to be compliant with All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19.

Concurrence
Gary Crockett, Chief Counsel

Attachment
1. Contracted Entities Covered by this Recommended Board Action
2. California State Plan Amendment (SPA) 18-004
3. All-Plan Letter (APL) 19-007: Non–Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018–19
4. Ground Emergency Medical Transport Quality Assurance Fee – News Flash published on June 28, 2018

/s/ Michael Schrader *8/28/19*
Authorized Signature **Date**

Attachment to the September 5, 2019 Board of Directors Meeting – Agenda Item 9

CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip Code
AMVI Care Health Network	600 City Parkway West, #800	Orange	CA	92868
CHOC Physicians Network + Children's Hospital of Orange County	1120 West La Veta Ave, Suite 450	Orange	CA	92868
Family Choice Medical Group, Inc.	15821 Ventura Blvd. #600	Encino	CA	91436
Fountain Valley Regional Hospital and Medical Center	1400 South Douglass, Suite 250	Anaheim	CA	92860
Heritage Provider Network, Inc.	8510 Balboa Blvd, Suite 150	Northridge	CA	91325
Kaiser Foundation Health Plan, Inc.	393 Walnut St	Pasadena	CA	91188
Monarch Health Plan, Inc.	11 Technology Dr.	Irvine	CA	92618
Prospect Health Plan, Inc.	600 City Parkway West, #800	Orange	CA	92868

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
San Francisco Regional Office
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

DIVISION OF MEDICAID & CHILDREN'S HEALTH OPERATIONS

February 7, 2019

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

Dear Ms. Cantwell:

Enclosed is an approved copy of California State Plan Amendment (SPA) 18-004, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on July 11, 2018. SPA 18-004 implements a one-year Quality Assurance Fee (QAF) program and reimbursement add-on for Ground Emergency Medical Transports (GEMT) provided by emergency medical transportation providers effective for the State Fiscal Year (SFY) 2018-19 from July 1, 2018 to June 30, 2019.

The effective date of this SPA is July 1, 2018. Enclosed are the following approved SPA pages that should be incorporated into your approved state plan:

- Supplement 29 to Attachment 4.19-B, pages 1-2

If you have any questions, please contact Cheryl Young at 415-744-3598 or via email at Cheryl.Young@cms.hhs.gov.

Sincerely,

[redacted]

Richard Allen
Acting Associate Regional Administrator
Division of Medicaid & Children's Health Operations

Enclosures

cc: Lindy Harrington, California Department of Health Care Services (DHCS)
Connie Florez, DHCS
Angel Rodriguez, DHCS
Angeli Lee, DHCS
Amanda Font, DHCS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 18 — 004

2. STATE: California

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX of the Social Security Act (Medicaid)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2018

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
Title 42 CFR 447 Subpart F & 42 CFR 433.68

7. FEDERAL BUDGET IMPACT
a. FFY ~~2018~~ $4,461,892
b. FFY 2019 $13,385,675

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
~~Supplement 28, page 1, Attachment 4.19-B~~
Supplement 29 to Attachment 4.19-B, pages 1-2

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
None

10. SUBJECT OF AMENDMENT
One-year reimbursement rate add-on for ground emergency medical transport services

11. GOVERNOR'S REVIEW *(Check One)*

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL
[redacted]

13. TYPED NAME
Mari Cantwell

14. TITLE
State Medicaid Director

15. DATE SUBMITTED
July 11, 2018

16. RETURN TO
Department of Health Care Services
Attn: Director's Office
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
July 11, 2018

18. DATE APPROVED
February 7, 2017

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
July 1, 2018

20. SIGNATURE OF REGIONAL OFFICIAL
/ s /

21. TYPED NAME
Richard Allen

22. TITLE Acting Associate Regional Administrator,
Division of Medicaid & Children's Health Operations

23. REMARKS

Box 6: CMS made a pen and ink change on 9/26/18 to add "42 CFR 433.68," the regulatory citation for permissible health-care related taxes. Box 8: CMS made a pen and ink change on 9/21/18 to add page 2, a new page with page 1, and to correct supplement number to 29. Box 12: DHCS added signature on 1/31/19.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

ONE-YEAR REIMBURSEMENT RATE ADD-ON FOR GROUND EMERGENCY MEDICAL TRANSPORT SERVICES

Introduction

This program provides increased reimbursement to ground emergency medical transport providers by application of an add-on to the Medi-Cal fee-for-service (FFS) fee schedule base rates for eligible emergency medical transportation services. The reimbursement rate add-on will apply to eligible Current Procedural Terminology (CPT) Codes, between July 1, 2018 and June 30, 2019. The base rates for emergency medical transportation services will remain unchanged through this amendment.

"Emergency medical transport" means the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT Codes A0429, A0427, and A0433.

Methodology

For State Fiscal Year (SFY) 2018-19, the reimbursement rate add-on is fixed for FY 2018-19. The resulting payment amounts are equal to the sum of the FFS fee schedule base rate for the SFY 2015-16 and the add-on amount for the CPT Code. The resulting total payment amount for CPT Codes A0429, A0427, and A0433 will be $339.00. The add-on is paid on a per-claim basis.

Service Code	Description	Current Payment	Add On Amount	Resulting Total Payment
A0429	Basic Life Support	$118.20	$220.80	$339.00
A0427	Advanced Life Support, Level 1	$118.20	$220.80	$339.00
A0433	Advanced Life Support, Level 2	$118.20	$220.80	$339.00

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

The resulting total payment amount of $339.00 is considered the Rogers rate, which is the minimum rate that managed care organizations can pay noncontract managed care emergency medical transport providers, for each state fiscal year the FFS reimbursement rate add-on is effective.

State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: June 14, 2019

ALL PLAN LETTER 19-007

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS[1]

SUBJECT: NON-CONTRACT GROUND EMERGENCY MEDICAL TRANSPORT PAYMENT OBLIGATIONS FOR STATE FISCAL YEAR 2018-19

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with information regarding increased reimbursement for Fee-For-Service (FFS) ground emergency medical transport (GEMT) for Current Procedural Terminology (CPT) codes A0429, A0427, and A0433. The increased FFS reimbursement will affect MCP reimbursement of out-of-network GEMT services as required by section 1396u-2(b)(2)(D) of Title 42 of the United States Code (USC), commonly referred to as "Rogers Rates."

BACKGROUND:
Pursuant to the Legislature's addition of Article 3.91 (Medi-Cal Emergency Medical Transportation Reimbursement Act) to the Welfare and Institutions Code (WIC) in 2017, DHCS established the GEMT Quality Assurance Fee (QAF) program. On February 7, 2019, DHCS obtained federal approval from the Centers for Medicare and Medicaid Services (CMS) for California State Plan Amendment (SPA) 18-004, with an effective date of July 1, 2018. SPA 18-004 implements a one-year QAF program and reimbursement add-on for GEMT provided by emergency medical transportation providers effective for State Fiscal Year (SFY) 2018-19 from July 1, 2018, to June 30, 2019.

POLICY:
In accordance with 42 USC Section 1396u-2(b)(2)(D), Title 42 of the Code of Federal Regulations part 438.114(c), and WIC Sections 14129-14129.7, MCPs must provide increased reimbursement rates for specified GEMT services to non-contracted GEMT providers.

Under WIC Section 14129(g), emergency medical transport is defined as the act of transporting an individual from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the patient by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes,

[1] This APL does not apply to Prepaid Ambulatory Health Plans.

ordinances, or regulations, excluding transportation by an air ambulance provider, that are billed with CPT codes A0429 (BLS Emergency), A0427 (ALS Emergency), and A0433 (ALS2), excluding any transports billed when, following evaluation of a patient, a transport is not provided.

For each qualifying emergency ambulance transport billed with the specified CPT codes, the total FFS reimbursement will be $339.00 for SFY 2018-2019. Accordingly, MCPs reimbursing non-contracted GEMT providers for those services must pay a "Rogers Rate" for a total reimbursement rate of $339.00 for each qualifying emergency ambulance transport provided during SFY 2018-19 and billed with the specified CPT codes.

At this time, the total reimbursement rate of $339.00 for each qualifying emergency ambulance transport billed with the specified CPT codes is time-limited, and is only in effect for SFY 2018-19 dates of service from July 1, 2018, to June 30, 2019. Increased reimbursement for the specified GEMT services may be extended into future fiscal years, and may include additional GEMT codes. If the reimbursement increase is extended, and/or includes additional GEMT codes, DHCS will provide MCPs with further guidance after necessary federal approval is obtained.

Timing of Payment and Claim Submission

The projected value of this payment obligation will be accounted for in the MCPs' actuarially certified risk-based capitation rates. Within 90 calendar days from the date DHCS issues the capitation payments to MCPs for GEMT payment obligations specified in this APL, MCPs must pay, as required by this APL, for all clean claims or accepted encounters with the dates of service between July 1, 2018, and the date the MCP receives such capitation payment from DHCS.

Once DHCS begins issuing the capitation payments to the MCPs for the GEMT payment obligations specified in this APL, MCPs must pay as required by this APL within 90 calendar days of receiving a qualifying clean claim or an accepted encounter.

MCPs are required to make timely payments in accordance with this APL for clean claims or accepted encounters for qualifying transports submitted to the MCPs within one year after the date of service. MCPs are not required to pay the GEMT payment obligation specified in this APL for claims or encounters submitted more than one year after the date of service unless the non-contracted GEMT provider can show good cause.

These submission and payment timing requirements may be waived only if agreed to in writing between the MCPs, the MCPs' delegated entities, or subcontractors, and the rendering GEMT provider.

Impacts Related to Medicare

For dual eligible beneficiaries with Medicare Part B coverage, the increased Medi-Cal reimbursement level may result in a crossover payment obligation on the MCP, because the new Medi-Cal reimbursement amount may exceed 80 percent of the Medicare fee schedule. Based on current Medicare reimbursement rates, the only CPT code where this scenario may occur in certain geographic areas is A0429. MCPs are responsible for identifying and satisfying any Medicare crossover payment obligations that result from the increase in GEMT reimbursement obligations described in this APL.

In instances where a member is found to have other health coverage sources, MCPs must cost avoid or make a post-payment recovery in accordance with the "Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources" provision of Attachment 2 to Exhibit E of the MCP Contract.

Other Obligations

MCPs are responsible for ensuring qualifying transports reported using the specified CPT codes are appropriate for the services being provided and are reported to DHCS in encounter data pursuant to APL 14-019.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs, policy letters, and duals plan letters. MCPs must communicate these requirements to all delegated entities and subcontractors.

Pursuant to the MCP Contract, MCPs must have a formal procedure to accept, acknowledge, and resolve provider grievances related to the processing or non-payment related to this APL. In addition, MCPs must identify a designated point of contact for provider questions and technical assistance.

If you have any questions regarding the requirements of this APL, please contact your Managed Care Operations Division contract manager.

Sincerely,

Original Signed by Sarah Brooks

Sarah Brooks, Deputy Director
Health Care Delivery Systems

Department of Health Care Services Medi-Cal

Ground Emergency Medical Transport Quality Assurance Fee

June 28, 2018

In accordance with Senate Bill 523 (Chapter 773, Statutes of 2017), the Department of Health Care Services (DHCS) has finalized the fiscal year 2018 – 2019 Ground Emergency Medical Transport Quality Assurance Fee (QAF) rate and add-on amount to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport, as listed below. The QAF is assessed on each qualified emergency medical transport, regardless of payer. The add-on will be provided in addition to the Medi-Cal fee-for-service fee schedule rates for the affected emergency medical transport billing codes. The fiscal year 2018 – 2019 QAF rate and add-on amount are as follows:

Add-on Amount: $220.80

QAF Rate: $24.80

The resulting fiscal year 2018 – 2019 total fee-for-service reimbursement amount will be $339 for HCPCS codes A0427, A0429 and A0433 (ground medical transportation services).

For more details regarding the Ground Emergency Medical Transport QAF Program and the reporting requirements and instructions, visit the Ground Emergency Medical Transport Quality Assurance Fee website.

Questions or comments may be submitted to the DHCS Ground Emergency Medical Transport QAF email box: GEMTQAF@dhcs.ca.gov.

Server:files.medi-cal.ca.gov |File:/pubsdoco/newsroom/newsroom_27057.asp |Last Modified:9/21/2018 5:14:04 PM

Policy:	FF.2011
Title:	**Directed Payments**
Department:	Claims Administration
Section:	Not Applicable
Interim CEO Approval:	*/s/ Richard Sanchez 04/15/2020*
Effective Date:	04/02/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This Policy establishes requirements pursuant to which CalOptima and a Health Network shall administer the Directed Payments for Qualifying Services, including processes for the reimbursement of Directed Payments by CalOptima to a Health Network and by a Health Network to its Designated Providers.

II. POLICY

A. CalOptima shall reimburse a Health Network for Directed Payments made to a Designated Provider for Qualifying Services in accordance with this Policy, including Attachment A of this Policy.

B. A Health Network shall qualify for the reimbursement of Directed Payments for Qualifying Services if:

1. The Health Network processed the Directed Payment to a Designated Provider in compliance with this Policy and applicable statutory, regulatory, and contractual requirements, as well as Department of Health Care Services (DHCS) guidance and Centers for Medicare & Medicaid Services (CMS) approved preprint;

2. The Qualifying Services were eligible for reimbursement (*e.g.,* based on coverage, coding, and billing requirements);

3. The Member or Eligible Member, as applicable and as those terms are defined in this Policy, was assigned to the Health Network on the date of service;

4. The Designated Provider was eligible to receive the Directed Payment;

5. The Qualifying Services were rendered by a Designated Provider on an eligible date of service;

6. The Health Network reimbursed the Designated Provider within the required timeframe, as set forth in Section III.B. of this Policy; and

7. The Health Network submits Encounter data and all other data necessary to ensure compliance with DHCS reporting requirements in accordance with Sections III.F. and III.G. of this Policy.

Back to Agenda Back to Item

C. A Health Network shall make timely Directed Payments to Designated Providers for the following Qualifying Services, in accordance with Sections III.A. and III.B. of this Policy:

1. An Add-On Payment for Physician Services and Developmental Screening Services.

2. A Minimum Fee Payment for Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and Ground Emergency Medical Transport (GEMT) Services.

D. A Health Network shall ensure that Qualifying Services reported using specified Current Procedural Terminology (CPT) Codes, Healthcare Common Procedure Coding System (HCPCS) Codes, and Procedure Codes, as well as the Encounter data reported to CalOptima, are appropriate for the services being provided, and are not reported for non-Qualifying Services or any other services.

E. A Health Network shall have a process to communicate the requirements of this Policy, including applicable DHCS guidance, to Designated Providers. This communication must, at a minimum, include:

1. A description of the minimum requirements for a Qualifying Service;

2. How Directed Payments will be processed;

3. How to file a grievance with the Health Network and second level appeal with CalOptima; and

4. Identify the payer of the Directed Payments. (i.e. Member's Health Network that is financially responsible for the specified Direct Payment.)

F. A Health Network shall have a formal procedure for the acceptance, acknowledgement, and resolution of provider grievances related to the processing or non-payment of a Directed Payment for a Qualifying Service. In addition, a Health Network shall identify a designated point of contact for provider questions and technical assistance.

G. Directed Payment Reimbursement

1. CalOptima shall reimburse a Health Network for a Directed Payment made to a Designated Provider for Qualifying Services in accordance with Sections III.C. and III.E. of this Policy.

   a. Until such time reimbursement for a Directed Payment is included in a Health Network's capitation payment, CalOptima shall reimburse a Health Network for a Directed Payment separately.

2. If DHCS provides separate revenue to CalOptima for a Directed Payment requirement in addition to standard revenue from DHCS, CalOptima shall provide a Health Network a supplemental payment in addition to the Health Network's primary capitation payment.

   a. A Health Network shall process a Directed Payment as a supplemental payment and CalOptima shall reimburse a Health Network in accordance with Section III.C. of this Policy.

   b. CalOptima shall reimburse a Health Network medical costs of a Directed Payment plus a 2% administrative component. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

3. If DHCS does not provide separate revenue to CalOptima and instead implements a Directed Payment as part of the Medi-Cal fee schedule change:

    a. A Health Network shall process a Directed Payment as part of the existing Medi-Cal fee schedule change process as outlined in CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule and CalOptima shall reimburse a Health Network in accordance with Sections III.C. and III.E. of this Policy.

    b. CalOptima shall reimburse a Health Network after the Directed Payment is distributed and the Health Network submits the Directed Payment adjustment reports as described in Section III.D. of this Policy.

H. On a monthly basis, CalOptima Accounting Department shall reimburse a Health Network the Estimated Initial Month Payment for a validated Directed Payment in accordance with Section III.E. of this Policy.

I. A Health Network may file a complaint regarding a Directed Payment received from CalOptima in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

J. CalOptima shall ensure oversight of the Directed Payment programs in accordance with CalOptima Policy GG.1619: Delegation Oversight.

III. PROCEDURE

A. Directed Payments for Qualifying Services

1. Physician Services: For dates of service on or after July 1, 2017, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers rendering Physician Services to an Eligible Member.

    a. Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Services Programs, and cost-based reimbursement clinics are not eligible to receive this Add-On Payment for Physician Services.

2. Developmental Screening Services: For dates of service on or after January 1, 2020, a Health Network shall make an Add-On Payment, in the amount and for the applicable CPT Code as specified in Attachment A of this Policy, to Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics rendering Developmental Screening Services to an Eligible Member. A Developmental Screening Service must be provided in accordance with the American Academy of Pediatrics/Bright Futures periodicity schedule and guidelines and must be performed using a standardized tool that meets CMS Criteria.

    a. The following Developmental Screening Services are eligible for an Add-On Payment:

        i. A routine screening when provided:

            1) On or before the first birthday;

            2) After the first birthday and before or on the second birthday; or

            3) After the second birthday and on or before the third birthday.

ii. Developmental Screening Services provided when medically necessary, in addition to routine screenings.

b. Development Screening Services are not subject to any prior authorization requirements.

c. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2 of this Policy to document the completion of the Development Screening Service with the applicable CPT Code without the modifier as specified in Attachment A of this Policy.

d. A Health Network shall require Eligible Contracted Providers identified in Section III.A.2. of this Policy to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the Developmental Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.2.d. of this Policy are made available to CalOptima and/or DHCS upon request.

f. In the event any of the provisions of Section III.A.2. of the Policy conflicts with the applicable requirements of DHCS guidance, CMS-approved preprint, regulations, and/or statutes, such requirements shall control.

3. ACEs Screening Services: For dates of service on or after January 1, 2020, a Health Network shall reimburse Eligible Contracted Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable HCPCS Code, for rendering ACEs screening services to an Eligible Member, who is a child or an adult through sixty-four (64) years of age.

a. A Minimum Fee Payment for ACEs Screening Services shall only be made to rendering Eligible Contracted Providers that:

i. Utilize either the PEARLS tool or a qualifying ACEs questionnaire, as appropriate;

ii. Bill using one of the HCPCS Code specified in Attachment A of this Policy based on the screening score from the PEARLS tool or ACEs questionnaire used; and

iii. Are on DHCS list of providers that have completed the state-sponsored trauma-informed care training, except for dates of service prior to July 1, 2020. Commencing July 1, 2020, Eligible Contracted Providers must have taken a certified training and self-attested to completing the training to receive the Directed Payment for ACEs Screening Services.

b. A Health Network is only required to make the Minimum Fee Payment to an Eligible Contracted Provider for rendering an ACEs Screening Service, as follows:

i. Once per year per Eligible Member screened by that Eligible Contracted Provider, for a child Eligible Member assessed using the PEARLS tool.

ii. Once per lifetime per Eligible Member screened by that Eligible Contracted Provider, for an adult Eligible Member through age sixty-four (64) assessed using a qualifying ACEs questionnaire.

c. With respect to an Eligible Contracted Provider, CalOptima shall only reimburse a Health Network for the Minimum Fee Payment in accordance with Section III.A.3.b. of this Policy.

d. A Health Network shall require Eligible Contracted Providers to document the following information in the Eligible Member's medical records:

i. The tool that was used to perform the ACEs Screening Service;

ii. That the completed screen was reviewed;

iii. The interpretation of results;

iv. Discussion with the Eligible Member and/or the Eligible Member's family; and

v. Any appropriate actions taken.

e. A Health Network shall ensure information set forth in Section III.A.3.d. of this Policy are made available to CalOptima and/or DHCS upon request.

4. Abortion Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse Eligible Contracted Providers and non-contracted Providers, as applicable, which are qualified to provide and bill for Abortion Services, a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing Abortion Services to a Member.

a. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

5. GEMT Services: For dates of service on or after July 1, 2018, a Health Network shall reimburse non-contracted GEMT Providers a Minimum Fee Payment, as specified in Attachment A of this Policy for the applicable CPT Code, for providing GEMT Services to a Member.

a. A Health Network shall identify and satisfy any Medicare crossover payment obligations that may result from the increase in GEMT Services reimbursement obligations.

b. In instances where a Member is found to have other sources of health coverage, a Health Network shall take appropriate action for cost avoidance and post-payment recovery, in accordance with its contractual obligations to CalOptima.

B. Timing of Directed Payments

1. Timeframes with Initial Directed Payment: When DHCS final guidance requires an initial Directed Payment for clean claims or accepted encounters received by the Health Network with specified dates of service (*i.e.,* between a specific date of service and the date CalOptima receives the initial funding from DHCS for the Directed Payment), a Health Network shall ensure the initial Directed Payment required by this Policy is made, as necessary, within ninety (90) calendar days of the date CalOptima receives the initial funding from DHCS for the Directed Payment. From the date CalOptima receives the initial funding onward, a Health

Network shall ensure subsequent Directed Payments required by this Policy are made within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or accepted encounter is received by the Health Network no later than one (1) year after the date of service.

a. Initial Directed Payment: The initial Directed Payment shall include adjustments for any payments previously made by a Health Network to a Designated Provider based on the expected rates for Qualifying Services set forth in the Pending SPA or based on the established Directed Payment program criteria, rates and Qualifying Services, as applicable, pursuant to Section III.B.4. of this Policy.

b. Abortion Services: For clean claims or accepted encounters for Abortion Services with specified dates of service (*i.e.,* between July 1, 2017 and the date CalOptima receives the initial funding for Directed Payment from DHCS) that are timely submitted to a Health Network and have not been reimbursed the Minimum Fee Payment in accordance with this Policy, a Health Network shall issue the Minimum Fee Payment required by this Policy in a manner that does not require resubmission of claims or impose any reductions or denials for timeliness.

2. Timeframes without Initial Directed Payment: When DHCS final guidance does not expressly require an initial Directed Payment under Section III.B.1 of this Policy, a Health Network shall ensure that Directed Payments required by this Policy are made:

   a. Within ninety (90) calendar days of receiving a clean claim or accepted encounter for Qualifying Services, for which the clean claim or encounter is received no later than one (1) year from the date of service.

   b. Retroactively within ninety (90) calendar days of DHCS final guidance when a clean claim or accepted encounter for Qualifying Services is received prior to such guidance.

3. Notice by CalOptima

   a. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the requirements of DHCS final guidance for each Directed Payment program for Qualifying Services by no later than fifteen (15) calendar days from the release date of DHCS final guidance.

   b. CalOptima Health Network Relations Department shall notify the Health Networks, in writing, of the date that CalOptima received the initial funding for the Directed Payment from DHCS, by no later than fifteen (15) calendar days from the date of receipt. This provision applies to initial funding received by CalOptima on or after April 1, 2020, provided that DHCS final guidance requires initial Directed Payment as set forth in Section III.B.1. of this Policy.

   c. If DHCS files a State Plan Amendment (SPA) with CMS for an extension of a Directed Payment program ("Pending SPA") and CalOptima Board of Directors or Chief Executive Officer, pursuant to DHCS written instruction, approves the continuation of payment of the Directed Payment before DHCS final guidance is issued, CalOptima Health Network Relations Department shall notify the Health Networks, in writing, to continue to pay the Directed Payment to Designated Providers for Qualifying Services with specified dates of service.

4. Extension of Directed Payment Program:

    a. Upon receipt of written notice from CalOptima under Section III.B.3.c. of this Policy, a Health Network shall reimburse a Designated Provider for a Directed Payment according to the expected rates and Qualifying Services for the applicable time period as set forth in the Pending SPA or, at a minimum, according to the previously established Directed Payment program criteria, rates, and Qualifying Services, as applicable, until such time as the DHCS issues the final guidance.

    b. A Health Network shall ensure timely reconciliation and compliance with the final payment provisions as provided in DHCS final guidance when issued.

5. GEMT Services: A Health Network is not required to pay the Add-On Payment for GEMT Services for claims or encounters submitted more than one (1) year after the date of service, unless the non-contracted GEMT Provider can show good cause for the untimely submission.

    a. Good cause is shown when the record clearly shows that the delay in submitting a claim or encounter was due to one of the following:

        i. The Member has other sources of health coverage;

        ii. The Member's medical condition is such that the GEMT Provider is unable to verify the Member's Medi-Cal eligibility at the time of service or subsequently verify with due diligence;

        iii. Incorrect or incomplete information about the subject claim or encounter was furnished by the Health Network to the GEMT Provider; or

        iv. Unavoidable circumstances that prevented the GEMT Provider from timely submitting a claim or encounter, such as major floods, fires, tornadoes, and other natural catastrophes.

C. Directed Payments Processing

1. On a monthly basis, CalOptima shall reimburse a Health Network after the Health Network distributes the Directed Payment and the Health Network submits the Directed Payment adjustment reports in accordance with Section III.D. of this Policy.

    a. The CalOptima Accounting Department shall reconcile and validate the data through the Directed Payment adjustment report process prior to making a final payment adjustment to a Health Network.

2. If a Health Network identifies an overpayment of a Directed Payment, a Health Network shall return the overpayment within sixty (60) calendar days after the date on which the overpayment was identified, and shall notify CalOptima Accounting Department, in writing, of the reason for the overpayment. CalOptima shall coordinate with a Health Network on the process to return the overpayment in accordance with CalOptima Policy FF.1001: Capitation Payments.

    a. CalOptima shall notify a Health Network of acceptance, adjustment or rejection of the overpayment no later than three (3) business days after receipt.

    b. If CalOptima adjusts or rejects the overpayment, CalOptima shall include the overpayment adjustment in the subsequent month's process.

c. In the event CalOptima identifies that Directed Payments were made by a Health Network to a non-Designated Provider, or for non-Qualifying Services, or for services provided to a non-Member or a non-Eligible Member, as applicable, such Directed Payments shall constitute an overpayment which CalOptima shall recover from the Health Network**.**

D. Directed Payment Adjustment Process

1. As soon as a Health Network has processed and paid a Designated Provider for a Directed Payment, a Health Network shall submit a Directed Payment adjustment report for Qualifying Services by the tenth (10th) calendar day after the month ends to CalOptima's secure File Transfer Protocol (sFTP) site. A Health Network shall submit an adjustment report using CalOptima's proprietary format and file naming convention.

2. CalOptima Information Services Department shall notify a Health Network of file acceptance or rejection no later than three (3) business days after receipt. CalOptima may reject a file for data completeness, accuracy or inconsistency issues. If CalOptima rejects a file, a Health Network shall resubmit a corrected file no later than the tenth (10th) calendar day of the following month. Any resubmission after the tenth (10th) calendar day of the month will be included in the subsequent month's process.

3. Upon request, a Health Network shall provide additional information to support a submitted Directed Payment adjustment report to CalOptima Accounting Department within five (5) business days of the request.

4. For a complete Directed Payment adjustment report accepted by CalOptima Accounting Department, CalOptima shall reimburse a Health Network's medical costs of a Directed Payment plus a 2% administrative component no later than the twentieth (20th) calendar day of the current month based upon prior month's data. CalOptima's obligation to pay a Health Network any administrative fees shall be contingent upon administrative component payments by DHCS to CalOptima for the Directed Payments.

E. Estimated Initial Month Payment Process

1. On a monthly basis, CalOptima shall issue an Estimated Initial Month Payment to a Health Network. During the first month of implementation, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network no later than the 10th of the implementing month and as follows:

   a. When available, the Estimated Initial Month Payment shall be based upon the most recent rolling three-month average of the paid claims; or

   b. If actual data regarding the specific services tied to a Directed Payment are not available, CalOptima shall base the Estimated Initial Month Payment on the expected monthly cost of those services.

2. Thereafter, CalOptima shall disburse the Estimated Initial Month Payment to a Health Network for a Directed Payment no later than the 20th of the month for services paid in that month.

3. CalOptima Accounting Department shall reconcile the prior month's Estimated Initial Month Payment against a Health Network's submitted Directed Payment adjustment report for the prior month. CalOptima shall adjust the current month's Estimated Initial Month Payment, either positively or negatively based upon the reconciliation.

4. Following the first month of implementation and thereafter, the Estimated Initial Month Payment, CalOptima Accounting Department shall disburse funds to a Health Network based upon the previous month's submitted Directed Payment adjustment report.

F. A Health Network shall report an Encounter in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such Encounter.

G. Reporting

1. A Health Network shall submit all data related to Directed Payments to the CalOptima Information Services Department through the CalOptima secure File Transport Protocol (sFTP) site in a format specified by CalOptima, and in accordance with DHCS guidance, within fifteen (15) calendar days of the end of the applicable reporting quarter. Reports shall include, at a minimum, the CPT, HCPCS, or Procedure Code, service month, payor (*i.e.,* Health Network, or its delegated entity or subcontractor), and rendering Designated Provider's National Provider Identifier. CalOptima may require additional data as deemed necessary.

   a. Updated quarterly reports must be a replacement of all prior submissions. If no updated information is available for the quarterly report, a Health Network must submit an attestation to CalOptima stating that no updated information is available.

   b. If updated information is available for the quarterly report, a Health Network must submit the updated quarterly report in the appropriate file format and include an attestation that a Health Network considers the report complete.

2. CalOptima shall reconcile the Health Network's data reports and ensure submission to DHCS within forty-five (45) days of the end of the applicable reporting quarter as applicable.

IV. ATTACHMENT(S)

A. Directed Payments Rates and Codes

V. REFERENCE(S)

A. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
B. CalOptima Policy FF.1001: Capitation Payments
C. CalOptima Policy FF.1002: CalOptima Medi-Cal Fee Schedule
D. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
E. CalOptima Policy GG.1619: Delegation Oversight
F. CalOptima Policy HH.1101: CalOptima Provider Complaint
G. California State Plan Amendment 19-0020: Regarding the Ground Emergency Medical Transport Quality Assurance Fee Program
H. Department of Health Care Services All Plan Letter (APL) 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status
I. Department of Health Care Services All Plan Letter (APL) 19-007: Non-Contract Ground Emergency Medical Transport Payment Obligations for State Fiscal Year 2018-19
J. Department of Health Care Services All Plan Letter (APL) 19-013: Proposition 56 Hyde Reimbursement Requirements for Specified Services
K. Department of Health Care Services All Plan Letter (APL) 19-015: Proposition 56 Physicians Directed Payments for Specified Services
L. Department of Health Care Services All Plan Letter (APL) 19-016: Proposition 56 Directed Payments for Developmental Screening Services

M. Department of Health Care Services All Plan Letter (APL) 19-018: Proposition 56 Directed Payments for Adverse Childhood Experiences Screening Services
N. Department of Health Care Services All Plan Letter (APL) 20-002: Non-Contracted Ground Emergency Medical Transport Payment Obligations

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
04/10/2020	Department of Health Care Services (DHCS) [file and use]

VII. BOARD ACTION(S)

Date	Meeting
06/06/2019	Regular Meeting of the CalOptima Board of Directors
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	04/02/2020	FF.2011	Directed Payments	Medi-Cal

IX. GLOSSARY

Term	Definition
Abortion Services	Specified medical pregnancy termination services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to a Member.
Add-On Payment	Directed Payment that funds a supplemental payment for certain Qualifying Services at a rate set forth by DHCS that is in addition to any other payment, fee-for-service or capitation, a specified Designated Provider receives from a Health Network.
Adverse Childhood Experiences (ACEs) Screening Services	Specified adverse childhood experiences screening services, as listed by the HCPCS Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member through the use of either the Pediatric ACEs and Related Life-events Screener (PEARLS) tool for children (ages 0 to 19 years) or a qualifying ACEs questionnaire for adults (ages 18 years and older). An ACEs questionnaire or PEARLS tool may be utilized for Eligible Members who are 18 or 19 years of age. The ACEs screening portion of the PEARLS tool (Part 1) is also valid for use to conduct ACEs screenings among adult Eligible Members ages 20 years and older. If an alternative version of the ACEs questionnaire for adult Eligible Members is used, it must contain questions on the 10 original categories of the ACEs to qualify.
American Indian Health Services Program	Programs operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area.
Centers for Medicare and Medicaid Services (CMS) Criteria	For purpose of this Policy, the use of a standardized tool for Developmental Screening Services that meets all of the following CMS criteria: 1. Developmental domains: The following domains must be included in the standardized developmental screening tool: motor, language, cognitive, and social-emotional; 2. Establish Reliability: Reliability scores of approximately 0.70 or above; 3. Established Findings Regarding the Validity: Validity scores for the tool must be approximately 0.70 or above. Measures of validity must be conducted on a significant number of children and using an appropriate standardized developmental or social-emotional assessment instrument(s); and 4. Established Sensitivity/Specificity: Sensitivity and specificity scores of approximately 0.70 or above.

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), the Child Health and Disability Prevention program (as set forth in Title 17, CCR, Division 1, Chapter 4, Subchapter 13, Article 4, beginning with section 6842), and the California Children's Services (as set forth in Title 22, CCR, Division 2, subdivision 7, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 2.985, beginning with section 14094.4) under the Whole-Child Model program effective July 1, 2019, to the extent those services are included as Covered Services under CalOptima's Medi-Cal Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), and Health Homes Program (HHP) services (as set forth in DHCS All Plan Letter 18-012 and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 3.9, beginning with section 14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders, or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not-withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Department of Health Care Services (DHCS)	The state department in California responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California).
Designated Providers	Include the following Providers that are eligible to receive a Directed Payment in accordance with this Policy and applicable DHCS All Plan Letter or other regulatory guidance for specified Qualifying Services for the applicable time period: 1. Eligible Contracted Providers for Physician Services, ACEs Screening Services, and Abortion Services; 2. Eligible Contracted Providers that are FQHCs, RHCs, and Indian Health Services Memorandum of Agreement (IHS-MOA) 638 clinics for Developmental Screening Services; 3. Non-contracted GEMT Providers for GEMT Services; and 4. Non-contracted Providers for Abortion Services.
Developmental Screening Services	Specified developmental screening services, as listed by the CPT Code for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member, in accordance with the American Academy of Pediatrics (AAP)/Bright Futures periodicity schedule and guidelines for pediatric periodic health visits at nine (9) months, eighteen (18) months, and thirty (30) months of age and when medically necessary based on Developmental Surveillance and through use of a standardized tool that meets CMS Criteria.
Developmental Surveillance	A flexible, longitudinal, and continuous process that includes eliciting and attending to concerns of an Eligible Member's parents, maintaining a developmental history, making accurate and informed observations, identifying the presence of risk and protective factors, and documenting the process and findings.
Directed Payment	An Add-On Payment or Minimum Fee Payment required by DHCS to be made to a Designated Provider for Qualifying Services with specified dates of services, as prescribed by applicable DHCS All Plan Letter or other regulatory guidance and is inclusive of supplemental payments.

Term	Definition
Eligible Contracted Provider	An individual rendering Provider who is contracted with a Health Network to provide Medi-Cal Covered Services to Members, including Eligible Members, assigned to that Health Network and is qualified to provide and bill for the applicable Qualifying Services (excluding GEMT Services) on the date of service. Notwithstanding the above, if the Provider's written contract with a Health Network does not meet the network provider criteria set forth in DHCS APL 19-001: Medi-Cal Managed Care Health Plan Guidance on Network Provider Status and/or in DHCS guidance regarding Directed Payments, the services provided by the Provider under that contract shall not be eligible for Directed Payments for rating periods commencing on or after July 1, 2019.
Eligible Member	For purpose of this Policy, a Medi-Cal Member who is not dually eligible for Medi-Cal and Medicare Part B (regardless of enrollment in Medicare Part A or Part D).
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services.
Estimated Initial Month Payment	A payment to a Health Network based upon the most recent rolling three-month average of Directed Payment program-specific paid claims. If actual data regarding the specific services tied to a Directed Payment are not available, this payment is based upon the expected monthly cost of those services. This payment will not include an administrative component.
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.
Ground Emergency Medical Transport (GEMT) Services	Specified ground emergency medical transport services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services and defined as the act of transporting a Member from any point of origin to the nearest medical facility capable of meeting the emergency medical needs of the Member, by an ambulance licensed, operated, and equipped, in accordance with applicable state or local statutes, ordinances, or regulations, excluding transportation by an air ambulance and/or any transports billed when, following evaluation of a Member, a transport is not provided.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, and Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned in that particular Health Network.
Member	For purpose 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 Program, or the United States Social Security Administration, who is enrolled in the CalOptima Medi-Cal program and assigned to a Health Network at the time Qualifying Services are rendered.

Term	Definition
Minimum Fee Payment	A Directed Payment that sets the minimum rate, as prescribed by DHCS, for which a specified Designated Provider must be reimbursed fee-for-service for certain Qualifying Services. If a Designated Provider is capitated for such Qualifying Services, payments should meet the differential between the Medi-Cal fee schedule rate and the required Directed Payment amount.
Provider	For purpose of this Policy, any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Physician Services	Specified physician services, as listed by the CPT Codes for the applicable period in Attachment A of this Policy, that are Covered Services provided to an Eligible Member.
Qualifying Services	Include only the following Covered Services: Physician Services, Developmental Screening Services, Adverse Childhood Experiences (ACEs) Screening Services, Abortion Services, and GEMT Services.
Rural Health Clinic (RHC)	An organized outpatient clinic or hospital outpatient department located in a rural shortage area, which has been certified by the Secretary, United States Department of Health and Human Services.

Policy:	FF.1005f
Title:	**Special Payments: Supplemental OB Delivery Care Payment**
Department:	Finance
Section:	Not Applicable
CEO Approval:	/s/ *Michael Schrader 08/08/2019*
Effective Date:	01/01/2010
Revised Date:	07/01/2019

I. PURPOSE

This policy defines the criteria for a **Health Network***, with the exception of Kaiser Foundation Health Plan, Inc. (Kaiser), to receive a supplemental obstetrical (OB) delivery care payment for qualifying **Covered Services** provided to a **Member** enrolled in Medi-Cal for dates of service on and after January 1, 2010, in accordance with this policy.

II. POLICY

A. Effective for dates of service on and after January 1, 2010, CalOptima shall make a supplemental payment for qualifying **Covered Services** that include OB delivery care at a rate set forth in the **Contract for Health Care Services**, in accordance with the terms and conditions of this Policy.

B. A **Health Network** shall qualify for the supplemental payment for **Covered Services** that include OB delivery care if:

1. On the date of delivery, the **Member** was eligible with CalOptima for less than six (6) consecutive months;

2. On the date of delivery, the **Member** was between fifteen (15) and forty-four (44) years of age;

3. For the physician supplemental OB delivery care payment, **Covered Services** include physician services for normal and C-section delivery and assistant surgeon services billed with any of the following Current Procedural Terminology (CPT) codes: 59400, 59409, 59510, 59514, 59610, 59612, 59618, 59620; and modifier codes AG, or 80, as applicable;

4. For the hospital supplemental OB delivery care payment, **Covered Services** include hospital inpatient services related to an obstetric stay billed with the following Revenue Codes: 720, 721, 722, or 729;

5. The **Health Network** reimbursed the **Provider** for the **Covered Service**;

6. The **Health Network** authorized such services; and

7. The **Health Network** submits **Encounter** data in accordance with Section III.A of this policy.

C. If a **Health Network** identifies an **Overpayment** of a supplemental OB delivery care payment, the **Health Network** shall return the **Overpayment** within sixty (60) calendar days after the date on which the **Overpayment** was identified, and shall notify CalOptima's Accounting Department, in writing, of the reason for the **Overpayment**. CalOptima shall coordinate with the **Health Network** on the process to return the **Overpayment**.

* Terms in **bold** are included in the Glossary.

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III. PROCEDURE

A. **Encounter** Data Submission

1. A **Health Network** shall report an **Encounter** in accordance with CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements, and within three hundred sixty-five (365) calendar days after the date of service as reported on such **Encounter**.

2. CalOptima shall qualify **Health Network Encounter** Data for valid CPT and Revenue codes, and report the valid **Encounters** for payment authorization.

B. A **Health Network** shall instruct a **Provider** to utilize the appropriate CPT and Revenue codes to bill for **Covered Services** provided to a **Member**.

C. Processing of Physician Claims

1. A **Health Network** shall process an eligible claim submitted by a **Provider** for physician services at a rate set forth in their contractual agreement.

2. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

D. Processing of Hospital Claims

1. **Physician Hospital Consortium (PHC)** or **Health Maintenance Organization (HMO)**

a. A **PHC** or **HMO** shall process an eligible claim submitted by a **Provider** for hospital inpatient services related to an obstetrical stay at a rate set forth in their contractual agreement.

b. CalOptima shall make a supplemental payment to a **Health Network** in accordance with Section III.E.2 of this Policy.

2. Shared Risk Group (SRG)

a. CalOptima shall process a claim for hospital inpatient services related to an obstetrical stay provided to a **Member** enrolled in an **SRG** in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a **Shared Risk Group.**

b. CalOptima shall make a supplemental payment funding adjustment to the Shared Risk Pool in accordance with Section III.E.1 of this Policy.

E. Hospital Supplemental OB Delivery Care Payment

1. **SRG**: CalOptima shall make a supplemental payment funding adjustment to a Shared Risk Pool at a rate set forth in the **Contract for Health Care Services** for a covered hospital inpatient obstetrical delivery based on actual claims paid in accordance with CalOptima Policy FF.1010: Shared Risk Pool.

2. **PHC** or **HMO**: CalOptima shall make a supplemental payment at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

F. Physician Supplemental OB Delivery Care Payment

1. CalOptima shall make a supplemental payment to a **Health Network** for physician services for normal and C-section delivery and assistant surgeon services at a rate set forth in the **Contract for Health Care Services** in effect on the date of service based on **Encounter** data submitted in accordance with Section III.A.1 of this Policy.

G. With the exception of payment funding adjustment to a Shared Risk Pool described in Section III.E.1 of this Policy, CalOptima shall:

1. Distribute physician supplemental payments one (1) time each quarter; and

2. Provide a Remittance Advice Detail (RAD) to the **Health Network** for each quarterly payment that includes the following information:

a. **Provider** name;

b. **Provider** identification number;

c. **Member** name;

d. **Member** identification number;

e. Date of service;

f. Bill code; and

g. Amount paid.

H. A **Health Network** has the right to file a complaint disputing CalOptima's supplemental OB delivery care payment in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy EE.1111: Health Network Encounter Reporting Requirements
C. CalOptima Policy FF.1010: Shared Risk Pool
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Title 42, Code of Federal Regulations (CFR), §438.608(d)(2)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
11/09/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2010	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	01/01/2014	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2015	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2016	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	04/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	06/01/2017	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2018	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal
Revised	07/01/2019	FF.1005f	Special Payments: Supplemental OB Delivery Care Payment	Medi-Cal

IX. GLOSSARY

Term	Definition
Contract for Health Care Services	The written instrument between CalOptima and Physicians, Hospitals, Health Maintenance Organizations (HMO), or other entities. Contract shall include any Memoranda of Understanding entered into by CalOptima that is binding on a Physician Hospital Consortium (PHC) or HMO, DHCS Medi-Cal Managed Care Division Policy Letters, Contract Interpretation, and Financial Bulletins issued pursuant to the Contract.
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), or other services as authorized by the Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Encounter	Any unit of Covered Services provided to a Member by a Health Network regardless of Health Network reimbursement methodology. Such Covered Services include any service provided to a Member regardless of the service location or provider, including out-of-network services and sub-capitated and delegated Covered Services
Health Maintenance Organization (HMO)	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.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.
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.
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.
Shared Risk Group (SRG)	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.

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.

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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 — *3/1/2013*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Contact

Belinda Abeyta, Executive Director Operations (714) 246-8400

Recommended Actions

The CalOptima OneCare Connect Member Advisory Committee (OCC MAC) recommends:

1. Reappointment of the following individuals to serve two-year terms on the OneCare Connect Member Advisory Committee, effective July 1, 2020 to June 30, 2022;
    a. Gio Corzo as the Community Based Adult Services (CBAS) Representative for a term ending June 30, 2022;
    b. Keiko Gamez as the Member/Family Member Representative for a term ending June 30, 2022;
    c. Donald Stukes as the Member Advocate Representative for term ending June 30, 2022; and
    d. Patty Mouton as the Representing Seniors Representative for a term ending June 30, 2022;
2. Appoint Eleni Hailemariam, M.D. as the non-voting Orange County Health Care Agency (OCHCA) Representative.

Background

The CalOptima Board of Directors welcomes community stakeholder involvement and benefits from their input in the form of advisory committees. The Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) established requirements for the implementation of the Cal MediConnect program, including a requirement for the establishment of a Cal MediConnect Member Advisory Committee. The CalOptima Board of Directors established the OneCare Connect Member Advisory Committee (OCC MAC) by resolution on February 5, 2015 to provide input and recommendations to the CalOptima Board relative to the OneCare Connect and the Cal MediConnect programs administered by CalOptima.

The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or family of members. There are also four non-voting members representing Orange County agencies. OCC MAC voting members serve two-year terms, with no limit on the number of terms a representative may serve. The six eats due to expire on June 30, 2020 include the Community Based Adult Services (CBAS), Long Term Services and Support, Member/Authorized Family Member (two seats), Member Advocate and Representing Seniors.

Discussion

CalOptima staff conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducted targeted community outreach to agencies and CBOs serving the various open position and posting recruitment materials on the CalOptima website. Staff also presented on the Board Advisory Committees at a Community Alliances Forum to enhance recruitment efforts.

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The OCC MAC Nominations Ad Hoc Subcommittee, composed of committee members Josefina Diaz, Sara Lee and Mario Parada met on June 16, 2020 and evaluated each of the applications for the available openings. The ad hoc presented the recommended slate of candidates for the six vacancies to the full committee on June 25, 2020. One OCC MAC Member Representative and a Long-Term Services and Support Representative will remain vacant until an eligible candidate is identified.

At the June 25, 2020 OCC MAC meeting, OCC MAC members voted to accept the recommended slate of candidates as proposed by the Nominations Ad Hoc and forwarded the proposed slate of candidates to the CalOptima Board for consideration

The candidates for the open positions are as follows:

Community Based Adult Services Representative
Gio Corzo*
Mr. Corzo is the Vice President of Home & Care Services for Meals on Wheels. He has twenty plus years of health care experience and expertise in strategic planning, development and operations of multiple health facilities, including CBAS centers, Day Programs and residential long-term care facilities. Mr. Corzo was instrumental in working on the State transition of Adult Day Health Care (ADHC) to CBAS. Mr. Corzo has served on the OCC MAC since 2015.

Member Representative
Keiko Gamez*
Ms. Gamez is a OneCare Connect member who is interested in serving others. She has experienced many difficulties in her life, but overcoming these experiences provides her the opportunity to make valuable contributions to the committee. Ms. Gamez also wants to help others who experience difficulties accessing care. She describes herself as a problem solver with skills to resolve difficult tasks. Ms. Gamez has been a member of the OCC MAC since 2018.

Member Advocate
Donald Stukes*
Donald Stukes is the Founder/Managing Director of Innovative Healthcare Solutions & Services whose mission is to improve lives with health care. A disabled veteran, Mr. Stukes is a Volunteer/Contractor/Affiliate at the Veterans Administration Medical Center in Long Beach where he advises Board members in the medical research areas on administrative and operational activities. He is also in training to provide behavioral health peer support/facilitating services. He is also an active member of the Orange County Veterans & Military Families Collaborative which represents over 103 public/private agencies to share information and currently sits on the Behavioral Health Working Group. Mr. Stukes is also an active volunteer with the Orange County Health Care Agency and a member of the California Healthcare Foundation. Mr. Stukes has been the Member Advocate on the OCC MAC since 2019.

*Indicates OCC MAC recommendation

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Representing Seniors

Meredith Chillemi

Meredith Chillemi is the LifeSTEPS Director of Aging and Education Services where she provides direct service to CalOptima Dual eligible older adults residing in affordable housing communities in Westminster, Brea and San Clemente. As a lead at LifeSTEPS, she guides programs at 10 senior affordable housing apartment communities in Orange County and regularly collaborates with CBAS, Senior Centers, the Office on Aging and serves on the County of Orange Senior Citizens Advisory Council Health and Nutrition Committee.

Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in the area of health care for older adults for 17 years. Ms. Mouton oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. In addition, Ms. Mouton speaks to community groups about issues of medical coverage and defining the continuum of care. Ms. Mouton is a current committee member of OCC MAC where she serves as its Chair. Ms. Mouton also currently holds the Long-Term Services and Supports Representative seat on CalOptima's Member Advisory Committee (MAC). Ms. Mouton has served on the OCC MAC since 2015.

Orange County Health Care Agency Representative

Eleni Hailemariam*

Eleni Hailemariam, M.D. is a board-certified Geriatric Psychiatrist who has been working at the OCHCA in its Behavior Health Services department since 2006. In her capacity as the Associate Medical Director for older adult services, she collaborates with community partners such as the older adult mental health council. Throughout her career, Dr. Hailemariam's primary interests has been pursuing services that integrate mental and physical health for older adults.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

As stated in policy, the OCC MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The OCC MAC met on June 25, 2020 to discuss the Ad Hoc's recommended slate of candidates and concurred with the Subcommittee's recommendations. The OCC MAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence

OneCare Connect Member Advisory Committee Nominations Ad Hoc
OneCare Connect Member Advisory Committee
Gary Crockett, Chief Counsel

*Indicates OCC MAC recommendation

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Attachments
None

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

*Indicates OCC MAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Appointments to the CalOptima Board of Directors' Whole-Child Family Advisory Committee

Contact

Belinda Abeyta, Executive Director Operations (714) 246-8400

Recommended Actions

The Whole-Child Model Family Advisory Committee recommends:

1. Reappointment of the following individuals to serve two-year terms on the Whole-Child Family Advisory Committee, effective upon Board approval;
    a. Cathleen Collins as an Authorized Family Member Representative for a term ending June 30, 2022; and
    b. Kristen Rogers as an Authorized Family Member Representative for a term ending June 30, 2022;
2. Appointment of the following individual to serve a two-year term on the Whole-Child Model Family Advisory Committee, effective upon Board approval:
    a. Maura Byron as a Community Based Organization Representative for a term ending June 30, 2022.

Background

Senate Bill 586 (SB 586) was signed into law on September 25, 2016 and authorized the establishment of the Whole-Child Model incorporating California Children's Services (CCS)-covered services for Medi-Cal eligible children and youth into specified county-organized health system plans, including CalOptima. A provision of the Whole-Child Model program requires each participating health plan to establish a family advisory committee. Accordingly, the CalOptima Board of Directors established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017 to report and provide input and recommendations to the CalOptima Board relative to the Whole-Child Model program.

The WCM FAC is comprised of eleven voting members, seven to nine of whom are to be designated as family representatives and two to four of whom are to be designated as community seats representing the interests of children receiving CCS services. While two of the WCM FAC's eleven seats are designated as community seats, WCM FAC candidates representing the community may be considered for up to two additional WCM FAC seats if there are not enough family representative candidates to fill these seats.

With the fiscal year ending on June 30, 2020, five (5) WCM FAC seats will expire: four Authorized Family Member Representatives and one (1) Community Based Organization Representative. For the current nomination process, the WCM FAC Ad Hoc members reviewed the applications from candidates on June 9, 2020 in preparation for the June 23, 2020 meeting.

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Discussion

CalOptima conducted a comprehensive outreach, including sending notifications to community-based organizations (CBOs), conducted targeted community outreach to agencies and CBOs serving the various open position and posting recruitment materials on the CalOptima website. Staff also presented on the Board Advisory Committees at a Community Alliances Forum to enhance recruitment efforts.

The WCM FAC Nominations Ad Hoc Subcommittee, composed of WCM FAC committee members Sandra Cortez-Schultz, Brenda Deeley and Monica Maier evaluated each of the application for the impending openings and forwarded the proposed slate of candidates for the five vacancies. Two Authorized Family Member Representative seats will remain vacant until eligible candidates are identified.

At the June 23, 2020 regular WCM FAC meeting, WCM FAC members accepted the recommended slate of candidates as proposed by the Nominations Ad Hoc Committee and requested that the proposed slate of candidates be forwarded to the CalOptima Board for consideration

The candidates for the open positions are as follows:

Authorized Family Member Representative

Cathleen Collins

Ms. Collins is an active consumer advocate whose child is currently a CalOptima and CCS member. Ms. Collins has held leadership posts with Children's Hospital of Orange County, (CHOC), Mission Hospital, United Cerebral Palsy of Orange County as well as, serving as a board member for the Extraordinary Lives Foundation. Ms. Collins has extensive knowledge of CCS services and is passionate about the special needs population having devoted her life to their benefit and welfare. Currently, Ms. Collins is an independent consultant and strategic partner for local non-profit organizations in healthcare and Catholic institutions. Clients include: Eternal Word Television Network (EWTN), Denver Health, Extraordinary Lives Foundation, Serving Kids Hope, Higher Talent, Hammer & Associates, and the Orthopedic Institute for Children in Los Angeles. She has been a member of the WCM FAC since 2019.

Kristen Rogers

Kristen Rogers is the mother of a young teenager who receives CCS services and currently a CalOptima member. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC and has been a member in good standing of the WCM FAC since 2018. In March of 2019, Ms. Rogers was appointed to the California Children Services Advisory Group which meets quarterly in Sacramento, CA and represents CalOptima and the WCM FAC at these meetings.

Community Based Organization Representative

Maura Byron

Ms. Byron is the Executive Director of the Family Support Network (FSN) and is the parent of a young adult who is a current CCS client but who will age out of CCS in September 2020. As the executive director, she assists families of children with complex health care needs to maneuver within the healthcare system and secure services. In addition, she responds to families' questions and provides peer

and emotional support. She has been the Chair of CalOptima's Whole-Child Model Family Advisory Committee since 2018.

Fiscal Impact

Each authorized family member representative appointed to the WCM FAC may receive a stipend of up to $50 per committee meeting attended. Funding for stipends provided to WCM FAC family representatives is a budgeted item under the CalOptima Fiscal Year 2020-21 Operating Budget. There is no additional fiscal impact related to the recommended actions.

Rationale for Recommendation

As stated in policy, the WCM FAC established a Nominations Ad Hoc to review the potential candidates for vacancy on the Committee. The WCM FAC met to discuss and concurred with the subcommittee's recommendations. The WCM FAC forwards the recommended slate of candidates to the Board of Directors for consideration.

Concurrence

Whole-Child Model Family Advisory Committee Nominations Ad Hoc
Whole-Child Model Family Advisory Committee
Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Sanchez — *07/29/2020*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item
15. Consider Appointment to the CalOptima Board of Directors' Member Advisory Committee

Contact
Belinda Abeyta, Executive Director, Operations, (714) 246-8400

Recommended Action
The CalOptima Member Advisory Committee (MAC) recommends appointment of the following agency-selected voting liaison representative to the Member Advisory Committee effective upon Board Approval:

a. Steven Thronson, Deputy Agency Director, as the Orange County Health Care Agency Representative.

Background
The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, the CalOptima Board appoints each member of the MAC for a two-year term with the exception of the two standing seats, the Orange County Health Care Agency representative and the Orange County Social Services Agency representative, which have an unlimited term. The Board is responsible for the final approval of all MAC members.

Discussion
Pursuant to Resolution No. 021495, the Orange County Health Care Agency (OCHCA) may submit a candidate as a recommendation to represent the OCHCA for a standing seat on the MAC. The OCHCA recommended the appointment of Steven Thronson, to serve as the Health Care Agency representative to the MAC. Upon consideration of the candidate at the June 11, 2020 MAC meeting, the MAC is unanimously recommending this appointment and is forwarding the candidate to the Board of Directors for consideration.

Orange County Health Care Agency Recommended Candidate
Steven Thronson

Steve Thronson is the Deputy Agency Director for Orange County Health Care Agency leading Regulatory/Medical Health Services including Emergency Medical Services, Employee Health, Health Disaster Management, Medical Safety Net, Whole Person Care, and Environmental Health Services. Mr. Thronson also serves on several nonprofit boards including OC American Red Cross and Chair of Diabetic Camping and Educational Services serving children with Type-1 diabetes and their families. Prior to rejoining the Health Care Agency in 2016, Mr. Thronson successfully led organizations covering the full continuum of health services in creating cultures and operations focused on providing high quality care and services. Some of these leadership positions included Stars Behavioral Health Group, DC Police and Fire Clinic, APS Healthcare a Medicaid specialty provider, Orange County Public Health,

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Phoenix Houses, Kaiser Permanente, and Cigna Healthcare. Mr. Thronson also served on CalOptima's Member Advisory Committee from 2002 – 2005.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Pursuant to Resolution No. 021495, the OCHCA may submit a candidate as a recommendation to represent the OCHCA in a standing seat on the MAC. All members of the MAC are appointed by the CalOptima Board of Directors. The recommendation is now being forwarded to the Board for final approval.

The Health Care Agency representative on the MAC is a standing seat and not subject to the recommended two (2) year term limit. The nominee has been appointed to the MAC seat by the OCHCA as per policy and recommended by the MAC at their June 11, 2020 meeting for the Board consideration.

Concurrence
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Adoption of Resolution Changing the Duration of Chair and Vice Chair Terms for the CalOptima Board of Directors' Advisory Committees and Authorize Policy and Procedure Updates to Reflect These Changes

Contact

Belinda Abeyta, Executive Director, Operations (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations (714) 246-8400

Recommended Action

1. Adopt Resolution Number 20-0806-01, to extend the Chair and Vice Chair term lengths from one to two years for the following CalOptima Board of Directors' Advisory Committees:
   a. Member Advisory Committee;
   b. OneCare Connect Member Advisory Committee;
   c. Provider Advisory Committee; and
   d. Whole-Child Model Family Advisory Committee

2. Authorize updates to the following Policies and Procedures in accordance with CalOptima's regular review process to reflect the recommended changes in duration of Chair and Vice Chair term lengths:
   a. AA.1219a: Member Advisory Committee
   b. CMC.1007: OneCare Connect Member Advisory Committee
   c. AA.1219b: Provider Advisory Committee
   d. AA.1271: Whole-Child Model Family Advisory Committee

Background

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement via its advisory committees. The CalOptima Board established the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) by resolution on February 14, 1995 to serve solely in an advisory capacity providing input and recommendations concerning the CalOptima program. The Board established the OneCare Connect Member Advisory Committee (OCC MAC) by resolution on February 5, 2015 to provide input and recommendations to the CalOptima Board relative to the OneCare Connect program, which is the Cal MediConnect (Medicare-Medicaid Plan) program administered by CalOptima. The Board established the Whole-Child Model Family Advisory Committee (WCM FAC) by resolution on November 2, 2017 to provide advice and recommendations to the Board and staff on issues concerning CalOptima's Whole-Child Model program.

The MAC is comprised of fifteen voting members, including two standing members that represent the Orange County Health Care Agency and the Orange County Social Services Agency, respectively. The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or relatives of those members. There are also four non-voting members representing various Orange County agencies. The PAC is comprised of fifteen voting

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members and includes a standing seat for a representative from the Orange County Health Care Agency. The Whole-Child Model Family Advisory Committee is comprised of 11 voting members with seven authorized Family Member seats and four seats for Consumer Advocates/Community Based Organization. The CalOptima Board is responsible for the appointment of all advisory committee members for each committee, typically for two year terms.

Discussion

The Chair and Vice Chair of each of these advisory committees are appointed annually by the Board of Directors at the recommendation of each respective committee. On December 3, 2019, a Joint Recruitment Ad Hoc Committee comprised of members of the MAC, OCC MAC and the PAC met to discuss term lengths for the committee Chair and Vice Chair positions and recommend that they be changed from their current one (1) year duration to a two (2) year duration for each committee because of mutual interest from the committees in having a chair and vice chair serve a two year term for continuity purposes. At their respective meetings on the following dates, the committees approved the recommendation of the Joint Recruitment Ad Hoc Committee to change the committee Chair and Vice Chair term lengths:

MAC: February 25, 2020
OCC MAC: February 27, 2020
PAC: December 12, 2019, and
WCM FAC: June 23, 2020.

CalOptima Policies & Procedures AA.1219a, CMC. 1007, AA.1219b, and AA.1271 provide guidance on MAC, OCC MAC, PAC and WCM FAC operations. Staff recommends that the Board approve updates to four policies, as outlined below, to reflect the recommendations of the Joint Recruitment Ad Hoc Committee to increase advisory committee chair and vice chair term lengths from one to two years:

1. **AA.1219a: Member Advisory Committee:** This policy defines the composition and role of the Member Advisory Committee and establishes a process for recruiting, evaluating, and selecting prospective candidates to the MAC including the Chair and the Vice Chair. The proposed revision includes the modification of the Chair and Vice Chair term from one year to two years.
2. **CMC.1007: One Care Connect Member Advisory Committee:** This policy defines the composition and role of the Member Advisory Committee for OneCare Connect, and establishes a process for recruiting, evaluating, and selecting prospective candidates to the OCC MAC including the Chair and the Vice Chair. The proposed revision includes modification of the Chair and Vice Chair term from one year to two years.
3. **AA1219b: Provider Advisory Committee:** This policy defines the composition and role of the Provider Advisory Committee and establishes a process for recruiting, evaluating, and selecting prospective candidates to PAC including the Chair and the Vice Chair. The proposed revision includes modification of the Chair and Vice Chair term from one year to two years.
4. **AA.1271: Whole-Child Model Family Advisory Committee:** This policy defines the composition and role of the Family Advisory Committee for Whole-Child Model and establishes a process for recruiting,

evaluating, and selecting prospective candidates to the WCM FAC, including the Chair and the Vice Chair. The proposed revision includes the modification of the Chair and Vice Chair term from one year to two years.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The advisory committees' members propose increasing the duration of Chair and Vice Chair appointments from one year to two years on the MAC, OCC MAC, PAC and WCM FAC for continuity purposes.

Concurrence
Member Advisory Committee
OneCare Connect Member Advisory Committee
Provider Advisory Committee
Whole-Child Model Family Advisory Committee
Gary Crockett, Chief Counsel

Attachments
1. Resolution 20-0806-01
2. AA.1219a: Member Advisory Committee
3. CMC.1007: OneCare Connect Member Advisory Committee
4. AA.1219b: Provider Advisory Committee
5. AA.1271: Whole-Child Model Family Advisory Committee

/s/ Richard Sanchez *07/29/2020*
Authorized Signature **Date**

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RESOLUTION NO. 20-0806-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

APPROVE BOARD ADVISORY COMMITTEES CHAIR AND VICE CHAIR TERM LIMITS

WHEREAS, the CalOptima Board of Directors established the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) pursuant to Resolution No. 95-0214 to represent the constituencies served by CalOptima and to advise the Board of Directors; and

WHEREAS, the Board established the OneCare Connect Cal MediConnect Member Advisory Committee (OCC MAC) pursuant to Resolution No. 15-0205 to represent the constituencies served by the OneCare Connect program (the Cal MediConnect program administered by CalOptima), and to advise the Board of Directors; and

WHEREAS, the Board established the Whole-Child Model Family Advisory Committee (WCM FAC) pursuant to Resolution No. 17-1102-01 to represent the constituencies by the Whole-Child Model program, and to advise the Board of Directors; and

WHEREAS, Resolution No. 95-0214 was amended to rename seats on the MAC and the PAC, pursuant to Resolution 20-0505-01 (MAC) and Resolution 20-0305-01(PAC); and

WHEREAS, Resolution No. 15-0205 was amended to add a Vice Chair Position to the OCC MAC.

WHEREAS, members of the MAC, OCC MAC, PAC and WCM FAC recommend that the term of the Chair and Vice Chair be changed from a one year term to a two year term.

NOW, THEREFORE, BE IT RESOLVED:

That the Board of Directors hereby approves and adopts the Chair and Vice Chair term of two years for the MAC, OCC MAC, PAC and the WCM FAC.

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APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 6th day of August 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: _____Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	02/14/1995
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's MAC.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), MAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages Member involvement in the CalOptima program.

C. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of MAC shall reflect the diversity of the health care consumer. All MAC members shall have direct or indirect contact with CalOptima Members.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995) and 11-1103 (effective in November 3, 2011), MAC shall be comprised of fifteen (15) voting members, each seat representing a constituency served by CalOptima.

1. Two (2) of the fifteen (15) positions are standing seats and are held by the Orange County Health Care Agency (HCA) and the Social Services Agency (SSA).

2. The remaining thirteen (13) members shall serve a two (2) year term with no limits on the number of terms a representative may serve.

   a. One (1) of the remaining thirteen (13) positions shall be a dedicated Consumer seat.

   b. The two (2) year term shall coincide with CalOptima's fiscal year (i.e., July 1 through June 30).

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3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

   a. Adult beneficiaries;

   b. Behavioral/Mental Health;

   c. Children;

   d. Consumer;

   e. Family Support Representative;

   f. Foster children;

   g. Long-Term Services and Supports (LTSS);

   h. Medi-Cal beneficiaries;

   i. Medical Safety Net;

   j. Orange County HCA;

   k. Orange County SSA;

   l. Persons with disabilities;

   m. Persons with Special Needs;

   n. Recipients of CalWORKs; or

   o. Seniors.

F. MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

   1. The MAC shall conduct an annual recruitment and nomination process.

      a. At the end of each fiscal year, approximately half of the MAC seats' terms expire, alternating between six (6) vacancies one (1) year and seven (7) vacancies the subsequent year. Standing seats in MAC are not impacted by term expiration.

   2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

      a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two (2) year term.

G. Special Elections

   1. Special elections for MAC shall occur under the following circumstances:

a. When a MAC seat is vacant due to the resignation of a sitting MAC member; or

b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

H. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

I. On a~~n~~ bi-annual basis, MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

L. MAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima staff prior to the MAC meeting. CalOptima staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the MAC as standing members.

   a. The MAC shall include the Public Health Officer (or his or her designee) of the HCA and the Director (or his or her designee) of the SSA.

   b. SSA and HCA representatives shall serve as standing members and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall meet at least quarterly.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum.

   a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not be limited to, the following:

   a. Outreach to the respective Member community;

   b. Placement of vacancy notices on the CalOptima Website; and

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. The MAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

D. CalOptima shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

    a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

    a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

    b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

    c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a chair, vice chair and a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

    a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

4. CalOptima shall provide new MAC members with a new member orientation.

IV. ATTACHMENT(S)

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee Applicant Evaluation Tool
D. Member Advisory Committee Seat Descriptions

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Board Resolution 2-14-95
D. CalOptima Board Resolution 06-0707
E. CalOptima Board Resolution 11-1103
F. CalOptima Board Resolution 13-0307
G. CalOptima Board Resolution 15-08-06-02

H. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/15/2014	Department of Health Care Services (DHCS)
08/11/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
11/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised		AA.1219a	Member Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
Member Advisory Committee	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

Policy:	AA.1219a
Title:	**Member Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	02/14/1995
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima's Member Advisory Committee (MAC) and to establish a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's MAC.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), MAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages Member involvement in the CalOptima program.

C. MAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of MAC shall reflect the diversity of the health care consumer. All MAC members shall have direct or indirect contact with CalOptima Members.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995) and 11-1103 (effective in November 3, 2011), MAC shall be comprised of fifteen (15) voting members, each seat representing a constituency served by CalOptima.

1. Two (2) of the fifteen (15) positions are standing seats and are held by the Orange County Health Care Agency (HCA) and the Social Services Agency (SSA).

2. The remaining thirteen (13) members shall serve a two (2) year term with no limits on the number of terms a representative may serve.

   a. One (1) of the remaining thirteen (13) positions shall be a dedicated Consumer seat.

   b. The two (2) year term shall coincide with CalOptima's fiscal year (i.e., July 1 through June 30).

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3. MAC may include, but is not limited to, individuals representing, or that represent the interests of:

   a. Adult beneficiaries;

   b. Behavioral/Mental Health;

   c. Children;

   d. Consumer;

   e. Family Support Representative;

   f. Foster children;

   g. Long-Term Services and Supports (LTSS);

   h. Medi-Cal beneficiaries;

   i. Medical Safety Net;

   j. Orange County HCA;

   k. Orange County SSA;

   l. Persons with disabilities;

   m. Persons with Special Needs;

   n. Recipients of CalWORKs; or

   o. Seniors.

F. MAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

   1. The MAC shall conduct an annual recruitment and nomination process.

      a. At the end of each fiscal year, approximately half of the MAC seats' terms expire, alternating between six (6) vacancies one (1) year and seven (7) vacancies the subsequent year. Standing seats in MAC are not impacted by term expiration.

   2. The MAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

      a. Candidates that fill a vacated seat mid-term shall complete the term for that specific seat, which will be less than a full two (2) year term.

G. Special Elections

   1. Special elections for MAC shall occur under the following circumstances:

a. When a MAC seat is vacant due to the resignation of a sitting MAC member; or

b. The current MAC member is deemed unqualified to serve in his or her current capacity as a MAC member.

2. Any new MAC member appointed to fill an open seat created mid-term shall serve the remainder of the resigning member's term.

H. MAC Vacancies

1. If a vacancy occurs prior to the start of the nomination process, there shall be no need for a special election and the vacant seat shall be filled during that nomination process.

2. If a vacancy occurs after the annual nomination process is complete, a special election may be conducted to fill the open seat, subject to approval by the MAC.

I. On a bi-annual basis, MAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-E of this policy.

1. The MAC chair and vice chair may serve one (1) two (2) year term.

2. The MAC chairperson or vice chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, the MAC chair or vice chair shall ask for three (3) to four (4) members to serve on the ad hoc subcommittee. MAC members, who are being considered for reappointment, cannot participate in the nomination ad hoc subcommittee.

1. The MAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-E of this policy; and

b. Forward the prospective chair, vice chair and slate of candidate(s) to the full MAC for consideration.

2. Following approval from the MAC, the recommended chair, vice chair and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair and vice chair appointments to the MAC.

L. MAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a MAC member provides notification of an absence to CalOptima staff prior to the MAC meeting. CalOptima staff shall maintain an attendance log of the MAC members' attendance at MAC meetings. Upon request from the MAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the MAC chair or vice chair shall contact any committee member who has three consecutive unexcused absences.

1. MAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. MAC composition

1. The composition of MAC shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the MAC as standing members.

   a. The MAC shall include the Public Health Officer (or his or her designee) of the HCA and the Director (or his or her designee) of the SSA.

   b. SSA and HCA representatives shall serve as standing members and shall not be subject to reapplying.

B. MAC meeting frequency

1. The MAC shall meet at least quarterly.

2. The MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum.

   a. A quorum must be present for any votes to be valid.

C. MAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit potential candidates utilizing a variety of notification methods, which may include, but are not be limited to, the following:

   a. Outreach to the respective Member community;

   b. Placement of vacancy notices on the CalOptima Website; and

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. The MAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

D. CalOptima shall conduct a special election with a truncated recruitment process to fill a MAC seat that has been vacated mid-term.

E. MAC nomination process

1. The MAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

    a. At the discretion of the MAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the MAC nomination ad hoc subcommittee meeting:

    a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the Applicant Evaluation Tool.

    b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair.

    c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the Applicant Evaluation Tool, the attendance record if relevant, and the prospective candidate's references.

F. MAC selection and approval process for prospective chair, vice chair and MAC candidates

1. Upon selection of a recommendation for a chair, vice chair and a slate of candidates, the ad hoc subcommittee shall forward its recommendation to the MAC for consideration.

2. Following consideration, the MAC's recommendation for a chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of MAC's recommendation, the new MAC members' terms shall be effective July 1.

    a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following MAC meeting.

4. CalOptima shall provide new MAC members with a new member orientation.

IV. ATTACHMENT(S)

A. Member Advisory Committee - Consumer Application
B. Member Advisory Committee - Community Application
C. Member Advisory Committee Applicant Evaluation Tool
D. Member Advisory Committee Seat Descriptions

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
C. CalOptima Board Resolution 2-14-95
D. CalOptima Board Resolution 06-0707
E. CalOptima Board Resolution 11-1103
F. CalOptima Board Resolution 13-0307
G. CalOptima Board Resolution 15-08-06-02

H. CalOptima Board Resolution 16-08-04-02

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
09/15/2014	Department of Health Care Services (DHCS)
08/11/2017	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
11/03/2011	Regular Meeting of the CalOptima Board of Directors
03/07/2013	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
05/07/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	08/04/2016	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	07/01/2017	AA.1219a	Member Advisory Committee	Medi-Cal
Revised	03/01/2020	AA.1219a	Member Advisory Committee	Medi-Cal
Revised		AA.1219a	Member Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
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.
Member Advisory Committee	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

CalOptima Seeks Candidates to Participate on its Member Advisory Committee

The CalOptima Board of Directors welcomes input and recommendations from the community regarding issues concerning CalOptima programs. For this reason, the CalOptima Board encourages members and community advocates to become involved through an advisory group known as the Member Advisory Committee (MAC).

The **Member Advisory Committee** advises the CalOptima Board of Directors and staff. The CalOptima MAC is composed of 15 members representing the various constituencies that CalOptima serves. The charge of the committee is to:

- Provide advice and recommendations to the CalOptima Board on issues concerning CalOptima programs as directed by the CalOptima Board.
- Engage in study, research and analysis of issues assigned by the Board or generated by the committee.
- Serve as a liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues relating to CalOptima programs.
- Initiate recommendations on issues for study to the CalOptima Board for their approval and consideration.
- Facilitate community outreach for CalOptima and the Board.

Currently, CalOptima is seeking a candidate to participate on its Member Advisory Committee. **Service on the MAC is voluntary and with no salary.** The following two-year seat is available:

- **Consumer Representative**

The committee encourages interested individuals who receive Medi-Cal or an Authorized Family Member of a Medi-Cal recipient to apply. To apply or to nominate an individual for the Member Advisory Committee, please mail, fax or email the attached candidate application along with a **biography or résumé** to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Fax: **714-571-2479** or email: csimmons@caloptima.org

If you have any questions, please call **714-347-5785**.

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MEMBER ADVISORY COMMITTEE

Member Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Phone: _____
Address: _____ Cell Phone: _____
City, State, ZIP: _____ Fax Number: _____
Email: _____

This seat serves a two-year term ending June 30, 2020.
☐ **Consumer**

Current position (e.g., title, student, volunteer, retired, etc.):_____

_____

1a. What is your direct or indirect experience working with the CalOptima population you wish to represent on the MAC?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

_____

_____

_____

2b. Include relevant experience related to working with diverse populations.

_____

_____

_____

3. What is your current understanding of managed care systems and/or CalOptima?

_____

_____

_____

_____

4a. Please explain why you wish to serve on CalOptima's MAC.

_____

_____

_____

_____

4b. Please explain why you would be a qualified representative to serve on the MAC.

_____

_____

_____

_____

5. Do you speak any of CalOptima's threshold languages besides English (Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic)?

_____

6. If selected, are you able to commit to a bimonthly MAC meeting as well as serve on at least one subcommittee? Yes ☐ No ☐

7. References (professional, community or personal):

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Address: _____ Address: _____

City, State, ZIP: _____ City, State, ZIP: _____

Phone: _____ Phone: _____

Email: _____ Email: _____

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and resumes, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's web site, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on the Member Advisory Committee requires that the person appointed must be a member or a family member or caregiver of a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**

I understand that by signing below and applying to serve on the MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

☐ **FAMILY MEMBER/CAREGIVER APPLICANT**

I understand that by my family member or caregiver applying to serve on the MAC, my status as a person eligible for Medi-Cal benefits is likely to become public. I authorize the incidental disclosing of my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

_____

Member (Printed Name)

_____ _____

Member (Signature) **Date**

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for or appointment to the CalOptima Member Advisory Committee**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the CalOptima Member Advisory Committee.**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Attn: Cheryl Simmons
Customer Service Department
505 City Parkway West
Orange, CA 92868

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I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that the health information used or disclosed as a result of my signing this authorization may not be further used or disclosed by the recipient unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative
(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Submit the completed application, your biography or résumé, and signed authorization forms to the address below or by email or secure fax:

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons
Email: csimmons@caloptima.org
Secure Fax: 714-571-2479

For questions, call 1-714-347-5785.

CalOptima Seeks Candidates to Participate on its Member Advisory Committee 2020–2022

The CalOptima Board of Directors welcomes input and recommendations from the community regarding issues concerning CalOptima programs. For this reason, the CalOptima Board encourages members and community advocates to become involved through an advisory group known as the Member Advisory Committee (MAC).

The **Member Advisory Committee** advises the CalOptima Board of Directors and staff. The CalOptima MAC is composed of 15 members representing the various constituencies that CalOptima serves. The charge of the committee is to:

- Provide advice and recommendations to the CalOptima Board on issues concerning CalOptima programs as directed by the CalOptima Board.
- Engage in study, research and analysis of issues assigned by the Board or generated by the committee.
- Serve as a liaison between interested parties and the Board.
- Assist the Board in obtaining public opinion on issues relating to CalOptima programs.
- Initiate recommendations on issues for study to the CalOptima Board for their approval and consideration.
- Facilitate community outreach for CalOptima and the Board.

At this time, CalOptima is seeking candidates to participate on its Member Advisory Committee. **Service on the MAC is voluntary and with no salary.** The following two-year seats are available for representatives of:

- **Children**
- **Foster Children**
- **Long-Term Services and Supports**
- **Medically Indigent Persons**
- **Persons with Mental Illness**
- **Persons with Special Needs**

The committee encourages interested individuals with knowledge and support of Medi-Cal and Medicare. To apply or to nominate an individual for the Member Advisory Committee, please mail, fax or email the attached candidate application by **March 31, 2020,** along with a **biography or resume** to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

Fax: **714-571-2479** or email: csimmons@caloptima.org

If you have any questions, please call **714-347-5785**.

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MEMBER ADVISORY COMMITTEE
Community Application

Instructions: Please answer all questions. You may write or type your answers. If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____

The following positions will serve a two-year term beginning July 1, 2020, through June 30, 2022.

Please indicate the seat for which you are applying:

☐ **Children**

☐ **Foster Children**

☐ **Long-Term Services and Supports**

☐ **Medically Indigent Persons**

☐ **Persons with Special Needs**

Current position (e.g., title, student, volunteer, retired, etc.):_____

_____

1a. What is your direct or indirect experience working with the CalOptima population you wish to represent on the Member Advisory Committee (MAC)?

_____

_____

_____

1b. Include any relevant community experience.

_____

_____

_____

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2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County?

2b. Include relevant experience related to working with diverse populations.

3. What is your current understanding of managed care systems and/or CalOptima?

4a. Please explain why you wish to serve on CalOptima's MAC.

4b. Please explain why you would be a qualified representative to serve on the MAC.

5. Do you speak any of CalOptima's threshold languages besides English (Spanish, Vietnamese, Farsi, Korean, Chinese or Arabic)? Please specify:_____

6. If selected, are you able to commit to a bimonthly MAC meeting as well as serve on at least one subcommittee? Yes ☐ No ☐

7. References (professional, community or personal):

Name: _____	Name: _____
Relationship:_____	Relationship: _____
Address: _____	Address: _____
City, State, ZIP: _____	City, State, ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published with the contact information removed as part of the Board Materials that are available on CalOptima's website and, even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

Submit with a biography or resume to:

CalOptima
Attn: Cheryl Simmons
505 City Parkway West
Orange, CA 92868

For questions, call **714-347-5785**.

Applications accepted through March 31, 2020

Completed applications may be submitted via fax to 714-571-2479 or email to csimmons@caloptima.org

Member Advisory Committee
2020–2022
Position Descriptions

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to Office of the Inspector General (OIG)/General Services Administration (GSA) verification and possible background checks

Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience representing CalOptima members directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks.

Long-Term Services and Supports Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who are in:
  - Intermediate Care Facility — Developmentally Disabled
  - Intermediate Care Facility — Developmentally Disabled — Nursing
  - Intermediate Care Facility — Developmentally Disabled — Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities — Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Medically Indigent Persons Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who utilize and are treated by:
  - Federally Qualified Health Centers (FQHCs)
  - Community Clinics
  - Recuperative Care Providers
  - Low Income Assistance Providers
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Mental Illness Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologist
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-Doctoral (BCBA-D)
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with special needs in pursuit of their health and wellness
- When license or credential is required, applicant must have active California license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be made by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

Member Advisory Committee

MAC Seat:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1a. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
1b. Include relevant community involvement	1–5	_____
2a. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
2b. Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4a. Expressed desire to serve on the MAC	1–5	_____
4b. Explanation why applicant is a qualified representative	1–5	_____
5. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
6. Availability and willingness to attend meetings	Yes/No	_____
7. Supportive references	Yes/No	_____
	Total Possible Points	35
_____ Name of MAC Evaluator	Total Points Awarded	_____

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2020 MAC Position Description

Adult Beneficiaries Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima adult members in pursuit of their health and wellness
- At least three years of employment in the field and/or three years of experience in field or "is a member with lived-experience"
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Representative (Formerly Persons with Mental Illness Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members with behavioral/mental health needs such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility or Hospital Psychiatric Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs

- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
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Consumer Representative

Position Description

- Must be a current CalOptima Medi-Cal member
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Family Support Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima families in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
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Foster Children Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima foster children in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience representing CalOptima members directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
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Long Term Services and Supports Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who are in:
  - Intermediate Care Facility – Developmentally Disabled
  - Intermediate Care Facility – Developmentally Disabled – Nursing
  - Intermediate Care Facility -Developmentally Disabled – Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities – Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
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Medi-Cal Beneficiaries Representative

Position Description

- Current CalOptima Medi-Cal member or current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima Medi-Cal beneficiaries
- When license or credential is required, applicant must have an active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima Medi-Cal members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Medical Safety Net Representative (Formerly Medically Indigent Persons Representative)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima members who utilize and are treated by:
  - Federally Qualified Health Centers (FQHCs)
  - Community Clinics
  - Recuperative Care Providers
  - Low Income Assistance Providers
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Disabilities Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with disabilities in pursuit of their health and wellness
- Candidate should represent an organization that does advocacy work on behalf of persons with disabilities with either direct medical or non-medical services for Medi-Cal members of all ages
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of CalOptima managed care systems and programs

- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Persons with Special Needs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima persons with special needs in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Recipients of CalWORKs Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and advocate for CalOptima CalWORKs members in pursuit of their health and wellness
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience as a CalWORKs recipient or representative
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute

- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Seniors Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input, and advocate for CalOptima seniors including, but not limited to:
  - Community Based Adult Services (CBAS) Centers
  - Community-Based Organization (CBO)
  - Senior centers
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Knowledge of CalOptima managed care systems and programs
- Minimum three years of experience directly representing CalOptima members
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Health Care Agency Representative (Standing Seat)

Position Description

- Represented by the Orange County Health Care Agency
- No term limits
- Must have understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Social Services Representative (Standing Seat)

Position Description

- Represents CalOptima members and is appointed by the Orange County Social Services Agency
- No term limits
- Must have understanding and familiarity with the diverse cultural and/or social environments of Orange County

- Availability and willingness to attend regular, special and ad hoc MAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

MAC Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between MAC and the Board of Directors
- Provides MAC Report to CalOptima Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

MAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special MAC meetings
- Facilitate in absence of the MAC Chair all MAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the MAC Chair between MAC and the Board of Directors
- Provide MAC Report to CalOptima Board of Directors' at monthly meetings when MAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Policy:	CMC.1007
Title:	**OneCare Connect Member Advisory Committee (OCC MAC)**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the composition and role of the Member Advisory Committee for OneCare Connect and establishes a process for recruiting, evaluating, and selecting prospective candidates to the OneCare Connect Member Advisory Committee (OCC MAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), the OCC MAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and staff in regards to OneCare Connect.

B. For the purpose of this Policy, OCC MAC shall also be referred to as an advisory committee.

C. CalOptima's Board encourages Member and Provider involvement in the CalOptima program.

D. Advisory committee Members shall recuse themselves from voting or from decisions where a conflict of interest may exist, and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

E. CalOptima shall provide timely reporting of information pertaining to the OCC MAC as requested by regulatory agencies.

F. The composition of the OCC MAC shall reflect the cultural diversity and special needs of the health care consumers within the OneCare Connect population. All OCC MAC Members shall have direct or indirect contact with CalOptima Members.

G. In accordance with CalOptima Board Resolution #15-0205-01, CalOptima shall convene the OCC MAC no later than the effective date of OneCare Connect. The OCC MAC shall be comprised of no more than ten (10) voting Members, each seat representing a CalOptima constituency. Except as noted below, each voting Member shall serve a two (2) year term with no limits on the number of terms a representative may serve. In order to stagger reappointments, the OCC MAC Members noted below will serve a one (1) year term in the first year and if reappointed, two (2) year terms thereafter.

1. Three (3) of the ten (10) voting Members shall be OneCare Connect Members or family Members of a OneCare Connect Member.

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2. The seven (7) remaining voting Members shall represent one (1) each of the following constituencies:

    a. Community-Based Adult Services (CBAS) Provider representative;

    b. Home and Community-Based Services (HCBS) representative serving persons with disabilities;

    c. HCBS representative serving seniors;

    d. HCBS representative serving Members from an ethnic or cultural community;

    e. In-Home Supportive Services (IHSS) Provider or union representative;

    f. Long-term care facility representative; and

    g. Member advocate, such as Health Insurance, Counseling and Advocacy Program, Legal Aid Society, or Public Law Center.

3. Except for initial appointments, OCC MAC voting Members shall serve two (2) year terms, with no limits on the number of terms a representative may serve. The initial appointments of voting Members will be divided between one (1) and two (2) year terms in order to stagger the reappointments. In the first year, one (1) of the OneCare Connect Member/family Member positions will be appointed for a one (1) year term. In addition, the seats designated for a voting Member to represent Members receiving CBAS, Members who are seniors, Members residing in a long-term care facility, and a Member advocate shall be appointed for a one (1) year term.

4. In addition to the voting Members, the following agencies shall be invited to identify a non-voting liaison to attend and share information with the OCC MAC:

    a. Orange County Social Services Agency;

    b. Orange County Community Resources Agency, Office on Aging;

    c. Orange County Health Care Agency, Mental Health Services; and

    d. Orange County In-Home Supportive Services Public Authority.

H. The OCC MAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

1. The OCC MAC shall conduct an annual recruitment and nomination process.

    a. At the end of a two (2) year term, half of the seats' terms expire and the OCC MAC shall recruit for the expiring seats.

I. OCC MAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the OCC MAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, the OCC MAC nomination ad hoc subcommittee shall conduct a recruitment.

3. A new OCC MAC Member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning Member's term, which may be less than a full two (2) year term.

J. On a~~n~~ bi-annual basis, OCC MAC shall select a chairperson and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection of the chairperson and vice chair shall be conducted in accordance with Section III.B-D of this Policy.

1. The OCC MAC chairperson and vice chair may serve ~~two~~ one (~~2~~1) ~~consecutive one~~ two (~~1~~2) year term~~s~~.

2. The OCC MAC chairperson and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The OCC MAC chairperson, or vice chair, shall ask for three (3) to four (4) Members from the OCC MAC to serve on a nomination ad hoc subcommittee. OCC MAC Members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The OCC MAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chairperson, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chairperson, vice chair, and slate of candidate(s) to the OCC MAC for review and approval.

2. Following approval from the OCC MAC , the recommended chairperson, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chairperson and vice chair appointments to the OCC MAC.

M. OCC MAC Members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a OCC MAC Member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the OCC MAC Members' attendance at OCC MAC meetings. Upon request from the OCC MAC chairperson, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the OCC MAC chair, or vice chair, shall contact any committee Member who has three (3) consecutive unexcused absences.

1. OCC MAC Members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. OCC MAC meeting frequency

1. OCC MAC shall meet bi-monthly; meeting frequency subject to change based on s special or unforeseen circumstances.

2. OCC MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after June of each year.

3. Attendance by a simple majority of appointed Members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. OCC MAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the OneCare Connect population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to the Member community;

   b. Placement of vacancy notices on the CalOptima website; and

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the OCC MAC chairperson, or vice chair, shall inquire of its membership whether there are interested candidates who wish to be considered as a chairperson or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first OCC MAC meeting whether there are interested candidates who wish to be considered as a chairperson for the first year.

C. OCC MAC nomination evaluation process

1. The OCC MAC chairperson or vice chair shall request three (3) to four (4) Members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) Members shall serve on the nominations ad hoc subcommittee to review non-Member candidates for OCC MAC.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advisement.

2. Prior to OCC MAC nomination ad hoc subcommittee meeting (including the initial OCC MAC nomination ad hoc subcommittee).

   a. Ad hoc subcommittee Members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

   b. Ad hoc subcommittee Members shall individually evaluate and select a chairperson and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee Members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chairperson, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. OCC MAC selection and approval process for prospective chairperson, vice chair and OCC MAC candidates

1. The nomination ad hoc subcommittee shall forward its recommendation for a chairperson, vice chair, and a slate of candidates to OCC MAC for review and approval. Following OCC MAC's approval, the proposed chairperson, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. Following the CalOptima Board's approval of the OCC MAC's recommendations, the initial OCC MAC Member terms shall be effective no later than the effective date of OneCare Connect.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend immediately following OCC MAC meeting.

3. CalOptima shall provide new OCC MAC Members with a new Member orientation.

IV. ATTACHMENT(S)

A. OneCare Connect Member Advisory Committee Application (Member)
B. OneCare Connect Member Advisory Committee Application (Community)
C. OneCare Connect Member Advisory Committee Applicant Evaluation Tool (Member)
D. OneCare Connect Member Advisory Committee Applicant Evaluation Tool (Community)

V. REFERENCE(S)

A. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Three-Way Contract with Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
C. Memorandum of Understanding (MOU) between CMS and The State of California regarding the California Demonstration to Integrate Care for Dual Eligible Beneficiaries, (March 2013), Section III.E.8.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/05/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	08/04/2016	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	08/01/2017	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	11/01/2018	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	01/01/2020	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	TBD	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect

IX. GLOSSARY

Term	Definition
Community Based Adult Services (CBAS)	Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family / caregiver training and support, nutrition services, and transportation to eligible beneficiaries, aged 18 years and older, blind, or disabled. ~~as defined in the California Bridge to Reform Waiver 11-W-00193/9, Special Terms and Conditions, Paragraph 91, to eligible Members who meet applicable eligibility criteria.~~
Home and Community-Based Services (HCBS)	Home and Community- Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Member	A~~n enrollee~~ beneficiary enrolled ~~of~~ in the CalOptima OneCare Connect program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.~~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.~~
Threshold Languages	Those languages identified based upon State requirements and/or findings of the ~~Group~~ Population Needs Assessment (~~GNA~~PNA).

Policy:	CMC.1007
Title:	**OneCare Connect Member Advisory Committee (OCC MAC)**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	
Applicable to:	☐ Medi-Cal ☐ OneCare ☒ OneCare Connect ☐ PACE ☒ Administrative

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B. For the purpose of this Policy, OCC MAC shall also be referred to as an advisory committee.

C. CalOptima's Board encourages Member and Provider involvement in the CalOptima program.

D. Advisory committee Members shall recuse themselves from voting or from decisions where a conflict of interest may exist, and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

E. CalOptima shall provide timely reporting of information pertaining to the OCC MAC as requested by regulatory agencies.

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    c. HCBS representative serving seniors;

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    g. Member advocate, such as Health Insurance, Counseling and Advocacy Program, Legal Aid Society, or Public Law Center.

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4. In addition to the voting Members, the following agencies shall be invited to identify a non-voting liaison to attend and share information with the OCC MAC:

    a. Orange County Social Services Agency;

    b. Orange County Community Resources Agency, Office on Aging;

    c. Orange County Health Care Agency, Mental Health Services; and

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    a. At the end of a two (2) year term, half of the seats' terms expire and the OCC MAC shall recruit for the expiring seats.

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2. If a seat is vacated after the annual nomination process is complete, the OCC MAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, the OCC MAC nomination ad hoc subcommittee shall conduct a recruitment.

3. A new OCC MAC Member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning Member's term, which may be less than a full two (2) year term.

J. On a bi-annual basis, OCC MAC shall select a chairperson and vice chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection of the chairperson and vice chair shall be conducted in accordance with Section III.B-D of this Policy.

1. The OCC MAC chairperson and vice chair may serve one (1) two (2) year term.

2. The OCC MAC chairperson and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The OCC MAC chairperson, or vice chair, shall ask for three (3) to four (4) Members from the OCC MAC to serve on a nomination ad hoc subcommittee. OCC MAC Members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The OCC MAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chairperson, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chairperson, vice chair, and slate of candidate(s) to the OCC MAC for review and approval.

2. Following approval from the OCC MAC , the recommended chairperson, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chairperson and vice chair appointments to the OCC MAC.

M. OCC MAC Members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a OCC MAC Member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the OCC MAC Members' attendance at OCC MAC meetings. Upon request from the OCC MAC chairperson, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the OCC MAC chair, or vice chair, shall contact any committee Member who has three (3) consecutive unexcused absences.

1. OCC MAC Members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. OCC MAC meeting frequency

1. OCC MAC shall meet bi-monthly; meeting frequency subject to change based on s special or unforeseen circumstances.

2. OCC MAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after June of each year.

3. Attendance by a simple majority of appointed Members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. OCC MAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the OneCare Connect population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to the Member community;

   b. Placement of vacancy notices on the CalOptima website; and

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the OCC MAC chairperson, or vice chair, shall inquire of its membership whether there are interested candidates who wish to be considered as a chairperson or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first OCC MAC meeting whether there are interested candidates who wish to be considered as a chairperson for the first year.

C. OCC MAC nomination evaluation process

1. The OCC MAC chairperson or vice chair shall request three (3) to four (4) Members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) Members shall serve on the nominations ad hoc subcommittee to review non-Member candidates for OCC MAC.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advisement.

2. Prior to OCC MAC nomination ad hoc subcommittee meeting (including the initial OCC MAC nomination ad hoc subcommittee).

   a. Ad hoc subcommittee Members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

   b. Ad hoc subcommittee Members shall individually evaluate and select a chairperson and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee Members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chairperson, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. OCC MAC selection and approval process for prospective chairperson, vice chair and OCC MAC candidates

1. The nomination ad hoc subcommittee shall forward its recommendation for a chairperson, vice chair, and a slate of candidates to OCC MAC for review and approval. Following OCC MAC's approval, the proposed chairperson, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. Following the CalOptima Board's approval of the OCC MAC's recommendations, the initial OCC MAC Member terms shall be effective no later than the effective date of OneCare Connect.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend immediately following OCC MAC meeting.

3. CalOptima shall provide new OCC MAC Members with a new Member orientation.

IV. ATTACHMENT(S)

A. OneCare Connect Member Advisory Committee Application (Member)
B. OneCare Connect Member Advisory Committee Application (Community)
C. OneCare Connect Member Advisory Committee Applicant Evaluation Tool (Member)
D. OneCare Connect Member Advisory Committee Applicant Evaluation Tool (Community)

V. REFERENCE(S)

A. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
B. CalOptima Three-Way Contract with Centers for Medicare & Medicaid Services (CMS) and Department of Health Care Services (DHCS) for Cal MediConnect
C. Memorandum of Understanding (MOU) between CMS and The State of California regarding the California Demonstration to Integrate Care for Dual Eligible Beneficiaries, (March 2013), Section III.E.8.

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
02/05/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	07/01/2015	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	08/04/2016	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	08/01/2017	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	11/01/2018	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	01/01/2020	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect
Revised	TBD	CMC.1007	OneCare Connect Member Advisory Committee	OneCare Connect

1

IX. GLOSSARY

Term	Definition
Community Based Adult Services (CBAS)	Outpatient, facility-based program that delivers skilled nursing care, social services, therapies, personal care, family / caregiver training and support, nutrition services, and transportation to eligible beneficiaries, aged 18 years and older, blind, or disabled.
Home and Community-Based Services (HCBS)	Home and Community- Based Services (HCBS) benefit is defined by the services listed in Title 42, Code of Federal Regulations, Section 440.182(c).
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Member	A beneficiary enrolled in the CalOptima OneCare Connect program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Member Advisory Committee (OCC MAC) Member Application

Instructions: Please answer all questions and type or print clearly. This application is for current OneCare Connect members and/or family members. Please attach a résumé or biography outlining your qualifications and signed disclosure forms. For questions, please call **1-714-347-5785**.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State, ZIP: _____ Fax Number: _____

Email: _____ Date: _____

These seats serve a two-year term beginning on July 1, 2020, and ending June 30, 2022:

☐ **OneCare Connect member or family member* (two seats available)**

* Applicants for the OneCare Connect member or family member seat must reside in Orange County and maintain enrollment as a OneCare Connect member or must be a family member of an enrolled OneCare Connect member.

OneCare Connect status (i.e., member or family member): _____

If you are a family member, please provide the member's name, and what your relationship is to the member: _____

1. Please tell us whether you have been a CalOptima member (i.e., Medi-Cal, OneCare) or have any consumer advocacy experience: _____

_____

_____

_____

2a. Please explain why you would be a good representative for diverse and/or special needs populations. _____

_____

_____

2b. Include any relevant experience working with these populations: _____

3. Please provide a brief description of your knowledge or experience as a dual eligible member (i.e., Medi/Medi), a member with traditional Medicare or a member in a Medicare Advantage Plan: _____

4. Please explain why you wish to serve on the OCC MAC: _____

5. Please describe why you would be a qualified representative for service on the OCC MAC:

6. Other than English, do you speak any of CalOptima's threshold languages for the OneCare Connect program (Spanish, Vietnamese, Korean, Farsi, Chinese and/or Arabic)? Please specify: _____

7. If selected, are you able to commit to attending a monthly OCC MAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name: _____ Relationship: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

Name: _____ Relationship: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-855-705-8823**. TTY users can call toll-free at **1-800-735-2929**.

Please sign the below *Public Records Act Notice; Limited Privacy Waiver* and the *Authorization for Use or Disclosure of Protected Health Information* form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACTS NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal program, unless the eligible member authorizes other disclosures. Because the position of Member Representative on the OneCare Connect Member Advisory Committee requires that the person appointed must be a member or a family member or caregiver of a member, the member's Medi-Cal eligibility will be disclosed to the general public. The member should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT**
I understand that by signing below and applying to serve on the OCC MAC, I am disclosing my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

☐ **FAMILY MEMBER/CAREGIVER APPLICANT**
I understand that by my family member or caregiver applying to serve on the OCC MAC, my status as a person eligible for Medi-Cal benefits is likely to become public. I authorize the incidental disclosing of my eligibility for the Medi-Cal program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.

OneCare Connect Member (Printed Name)

OneCare Connect Member (Signature) **Date**

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-855-705-8823**. TTY users can call toll-free at **1-800-735-2929**.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations require that you complete this form to authorize CalOptima to use or disclose your protected health information (PHI) to another person or organization. Please complete, sign and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Medi-Cal beneficiary status and any information member chooses to disclose in connection with his or her application for or appointment to the CalOptima OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee**

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow service as beneficiary representative on the OneCare Connect Plan (Medicare-Medicaid Plan) Member Advisory Committee.**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke**: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

*** Revocation of this authorization will immediately terminate involvement in the OCC MAC.*

RESTRICTIONS:

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-855-705-8823**. TTY users can call toll-free at **1-800-735-2929**.

I understand that certain information (e.g. Medi-Cal beneficiary status and name) used or disclosed as a result of my signing this authorization may be further used or disclosed in accordance with the California Public Records Act. Information precluded from the Public Records Act maintained by CalOptima will not be used or disclosed unless another authorization is obtained from me or unless such use or disclosure is specifically permitted or required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.

Mail or email the completed application and résumé or bio, signed *Public Records Act Notice, Limited Privacy Waiver* form and the *Use or Disclosure of Protected Health Information* form to: CalOptima, Attn: Cheryl Simmons, 505 City Parkway West, Orange, CA 92868, csimmons@caloptima.org or fax to 1-714-571-2479. For questions, call 1-714-347-5785.

This information is available for free in other languages. Please call our Customer Service department toll-free at **1-855-705-8823**. TTY users can call toll-free at **1-800-735-2929**.

OneCare Connect CalOptima
A Public Agency
Better. Together.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Member Advisory Committee (OCC MAC) Community Application

Recruitment Year 2020

Instructions: Please answer all questions and type or print clearly. Please attach a résumé or biography outlining your qualifications. For questions, please call **1-714-347-5785**.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State, ZIP: _____ Fax Number: _____

Email: _____ Date: _____

Term for each of the seats below runs from July 1, 2020, through June 30, 2022. These positions represent the following OneCare Connect population:

☐ Community-Based Adult Services (CBAS) Provider

☐ Long-Term Services and Supports Provider

☐ Member Advocate

☐ Representing Seniors

Current position (e.g., title, student, volunteer, retired, etc.): _____

1a. Provide a brief description of your direct or indirect experience working with the CalOptima dual eligible population and/or the constituency you wish to represent on the OCC MAC.

_____

_____

_____

_____

1b. Include any relevant community experience: _____

2a. What is your understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County? _____

2b. Include any relevant experience working with diverse populations: _____

3. What is your understanding of and experience with managed care systems and/or CalOptima?

4. Please explain why you wish to serve on the OCC MAC: _____

5. Describe why you would be a qualified representative for service on the OCC MAC:

6. Other than English, do you speak any of CalOptima's threshold languages for the OneCare Connect program (Spanish, Vietnamese, Korean, Farsi, Chinese and/or Arabic)? Please specify: _____

7. If selected, are you able to commit to attend a bi-monthly or quarterly OCC MAC meeting, as well as serve on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name: _____ Relationship: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

Name: _____ Relationship: _____

Address: _____ City, State, ZIP: _____

Phone: _____ Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature Date

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Cheryl Simmons

Fax: **1-714-571-2479**
Email: csimmons@caloptima.org
For questions, call **1-714-347-5785**

Application must be received by March 31, 2020.

OneCare Connect Member Advisory Committee (OCC MAC)
Member/Family Member Seat - Evaluation Tool (use one per applicant)

Applicant Name: **Initials**_____
OCC MAC Member/Family Member Seat

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements:
5 is Excellent; 4 is Very good; 3 is Average; 2 is Fair; 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Is applicant currently a OneCare Connect member or family member of a member?	1–5	_____
Relevant consumer advocacy experience	1–5	_____
2. Does applicant explain why he/she would be a good representative for diverse cultural and/or special needs populations?	1–5	_____
Relevant experience working with these populations	1–5	_____
3. Knowledge or experience with duals, Medicare, Medicare Advantage	1–5	_____
4. Does applicant explain why he/she wishes to serve on the OCC MAC?	1–5	_____
5. Explanation why he/she would be a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Points Awarded	_____
	Total Possible Points	35

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OneCare Connect Member Advisory Committee (OCC MAC)
Community Seat Applicant Evaluation Tool (use one per applicant)

Applicant Name: **Initials** _____
OCC MAC Seat Applying for:

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements:
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Relevant community experience	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Relevant experience working with such populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the OCC MAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Points Awarded	_____
	Total Possible Points	35

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Policy:	AA.1219b
Title:	**Provider Advisory Committee**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima's Provider Advisory Committee (PAC) and establishes a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's PAC.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), PAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages Provider involvement in the CalOptima program.

C. PAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of PAC shall reflect the diversity of the healthcare Provider community. All PAC Members shall have direct or indirect contact with CalOptima Members.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995), 06-0707 (effective in July 7, 2006), and 15-0806-02 (effective July 1, 2015), PAC shall be comprised of fifteen (15) voting Members, each seat representing a constituency that works with CalOptima and its Members.

1. One (1) of the fifteen (15) positions is a standing seat represented by the Orange County Health Care Agency (HCA).

2. The remaining fourteen (14) Members shall serve staggered terms of three (3) years.

   a. The three (3) year term shall coincide with CalOptima's fiscal year (i.e., July 1st through June 30th).

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b. Effective July 1, 2015, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

i. In order to achieve the staggered rate of one-third (1/3) each year, effective upon the completion date of the current term for the remaining eleven (11) PAC seats. The length of a term for the Allied Health Services seat, Health Network seat and Nurse seat will extend from a two (2)-year term to a three (3)-year term.

c. PAC Members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years in the category of membership they hold.

d. PAC Members shall be allowed to reapply after a hiatus of one (1) year.

i. PAC Members may submit an application for a different category of membership without a hiatus, if they qualify for the new category for which they are applying.

ii. In the event that a vacancy occurs, in which there are no qualified applicants, PAC shall approach the current incumbent to serve one (1) additional term.

iii. If the incumbent chooses not to serve, a special election shall be conducted, in accordance with this policy.

3. PAC may include, but is not limited to, individuals representing, or that represent the interest of:

a. Allied Health Services Providers (two (2) seats);

b. Behavioral/Mental health Providers;

c. Community Health Centers;

d. Health Networks;

e. Hospitals;

f. Long Term Services and Supports;

g. Nurses;

h. Non-Physician Medical Practitioners;

i. Orange County HCA;

j. Physicians (three seats);

k. Pharmacists; or

l. Safety Net Providers.

F. PAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. PAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately one-third (1/3) of the seat terms expire on PAC, alternating between six (6) vacancies one (1) year and four (4) vacancies each of the following two (2) years. Standing seat in PAC is not impacted by term expiration.

2. PAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated set mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term for PAC.

G. Special Elections for PAC

1. Special elections for PAC shall occur under the following circumstances:

a. When a PAC seat is vacant due to the resignation of a sitting PAC Member; or

b. The current PAC Member is deemed unqualified to serve in his or her current capacity as a PAC Member;

2. Any new Member appointed to fill an open seat created mid-term shall serve the remainder of the resigning Member's term.

H. PAC Vacancies

1. If the vacancy occurs prior to the start of the nomination process, there shall be no need for a special election, and the vacant seat shall be filled during that nomination process.

2. If the vacancy occurs after the annual nomination process is complete then a special election may be conducted to fill the open seat, subject to approval by the PAC.

I. On a~~n~~ bi-annual basis, PAC shall select a chair and vice-chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-G of this policy.

1. The PAC chair and vice-chair may serve one (1) two (2) year term.

2. The PAC chair and vice-chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, PAC chair shall ask for three (3) to four (4) Members to serve the ad hoc subcommittee. PAC Members, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each PAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair and vice-chair as well as a candidate for each of the open seats, in accordance with Section III. C-G of this policy; and

b. Forward the prospective chair's and vice-chair's name and slate of candidate(s) to the full advisory committee for review and approval.

2. Following approval from the full PAC, the recommended chair and vice chair as well as the slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair appointments to PAC.

L. PAC Members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a PAC Member provides notification of an absence to CalOptima staff prior to the PAC meeting. CalOptima staff shall maintain an attendance log of the PAC Members' attendance at PAC meetings. Upon request from the PAC chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the chair of the PAC shall contact any committee Member who has three consecutive unexcused absences.

1. PAC Members' attendance shall be considered as a criterion upon reappointment.

III. PROCEDURE

A. PAC composition

1. The composition of PAC shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the advisory committee as standing Members.

a. The PAC shall include the Director (or his or her designee) of the HCA.

b. HCA representative shall serve as a standing Member and shall not be subject to reapplying.

B. PAC meeting frequency

1. PAC shall meet at least quarterly.

2. PAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed Members shall constitute a quorum.

a. A quorum must be present for any votes to be valid and a quorum consists of half (1/2) total membership plus one.

C. PAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

a. Outreach to the respective Provider community;

b. Placement of vacancy notices on the CalOptima website; and

c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. During the PAC meeting held in March, the chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. An application is not required for the chair or vice-chair nomination.

D. PAC nomination process

1. The PAC chair or vice-chair shall request three (3) to four (4) Members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

   a. At the discretion of the PAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the PAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee Members shall individually evaluate and score the application for each of the prospective candidates using the Application Evaluation Tool.

   b. The ad hoc subcommittee Members shall individually evaluate and select a chair.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Application Evaluation Tool, the attendance record if relevant, and the prospective candidate's letters of support.

   a. At the discretion of the ad hoc subcommittee, subcommittee Members may contact a prospective candidate's references for additional information and background validation.

E. Term limits and length of term for PAC Members

1. Pursuant to the Board approved Resolution 15-08-06-02, effective July 1, 2015 PAC Members are appointed for three-year terms by the CalOptima Board of Directors with two consecutive term limits.

F. CalOptima shall conduct a special election with a truncated recruitment and nomination process to fill a PAC seat that has been vacated mid-term.

G. PAC selection and approval process for prospective chairs and candidates

1. Upon selection of a recommendation for a chair and vice-chair, as well as the slate of candidates, the ad hoc subcommittee shall forward its recommendation to the PAC for consideration.

2. Following consideration, the PAC's recommendation for a chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of PAC's recommendations, the new PAC Members' terms shall be effective July 1.

4. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following PAC meeting.

5. CalOptima shall provide new PAC Members with a new Member orientation.

IV. ATTACHMENT(S)

A. PAC Nomination Position Descriptions
B. PAC Application Evaluation Tool (AET)
C. PAC Application

V. REFERENCE(S)

A. CalOptima Board Resolution 2-14-95
B. CalOptima Board Resolution 06-0707
C. CalOptima Board Resolution 15-0806-02
D. CalOptima Board Resolution 16-0804-02
E. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
07/07/2006	Regular Meeting of the CalOptima Board of Directors
08/06/2015	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
03/05/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/04/2016	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2017	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	03/05/2020	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

1

IX. GLOSSARY

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.~~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.~~
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima Provider community.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

Policy:	AA.1219b
Title:	**Provider Advisory Committee**
Department:	Network Operations
Section:	Provider Relations
CEO Approval:	
Effective Date:	07/01/2015
Revised Date:	
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☒ PACE ☐ Administrative

I. PURPOSE

This policy describes the composition and role of CalOptima's Provider Advisory Committee (PAC) and establishes a process for recruiting, evaluating, and selecting prospective candidates to CalOptima's PAC.

II. POLICY

A. As directed by CalOptima's Board of Directors (CalOptima Board), PAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board relative to CalOptima's programs.

B. CalOptima's Board encourages Provider involvement in the CalOptima program.

C. PAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. The composition of PAC shall reflect the diversity of the healthcare Provider community. All PAC Members shall have direct or indirect contact with CalOptima Members.

E. In accordance with CalOptima Board Resolution Numbers 2-14-95 (effective in February 14, 1995), 06-0707 (effective in July 7, 2006), and 15-0806-02 (effective July 1, 2015), PAC shall be comprised of fifteen (15) voting Members, each seat representing a constituency that works with CalOptima and its Members.

1. One (1) of the fifteen (15) positions is a standing seat represented by the Orange County Health Care Agency (HCA).

2. The remaining fourteen (14) Members shall serve staggered terms of three (3) years.

   a. The three (3) year term shall coincide with CalOptima's fiscal year (i.e., July 1st through June 30th).

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b. Effective July 1, 2015, staggered nominations shall occur at a rate of approximately one-third (1/3) of the membership each year.

i. In order to achieve the staggered rate of one-third (1/3) each year, effective upon the completion date of the current term for the remaining eleven (11) PAC seats. The length of a term for the Allied Health Services seat, Health Network seat and Nurse seat will extend from a two (2)-year term to a three (3)-year term.

c. PAC Members may serve no more than two (2) consecutive terms or the equivalent of six (6) consecutive years in the category of membership they hold.

d. PAC Members shall be allowed to reapply after a hiatus of one (1) year.

i. PAC Members may submit an application for a different category of membership without a hiatus, if they qualify for the new category for which they are applying.

ii. In the event that a vacancy occurs, in which there are no qualified applicants, PAC shall approach the current incumbent to serve one (1) additional term.

iii. If the incumbent chooses not to serve, a special election shall be conducted, in accordance with this policy.

3. PAC may include, but is not limited to, individuals representing, or that represent the interest of:

a. Allied Health Services Providers (two (2) seats);

b. Behavioral/Mental health Providers;

c. Community Health Centers;

d. Health Networks;

e. Hospitals;

f. Long Term Services and Supports;

g. Nurses;

h. Non-Physician Medical Practitioners;

i. Orange County HCA;

j. Physicians (three seats);

k. Pharmacists; or

l. Safety Net Providers.

F. PAC shall conduct a nomination process to recruit potential candidates for the impending vacant seats, in accordance with this policy.

1. PAC shall conduct an annual recruitment and nomination process.

a. At the end of each fiscal year, approximately one-third (1/3) of the seat terms expire on PAC, alternating between six (6) vacancies one (1) year and four (4) vacancies each of the following two (2) years. Standing seat in PAC is not impacted by term expiration.

2. PAC shall conduct a recruitment and nomination process if a seat is vacated mid-term.

a. Candidates that fill a vacated set mid-term shall complete the term for that specific seat, which will be less than a full three (3) year term for PAC.

G. Special Elections for PAC

1. Special elections for PAC shall occur under the following circumstances:

a. When a PAC seat is vacant due to the resignation of a sitting PAC Member; or

b. The current PAC Member is deemed unqualified to serve in his or her current capacity as a PAC Member;

2. Any new Member appointed to fill an open seat created mid-term shall serve the remainder of the resigning Member's term.

H. PAC Vacancies

1. If the vacancy occurs prior to the start of the nomination process, there shall be no need for a special election, and the vacant seat shall be filled during that nomination process.

2. If the vacancy occurs after the annual nomination process is complete then a special election may be conducted to fill the open seat, subject to approval by the PAC.

I. On a bi-annual basis, PAC shall select a chair and vice-chair from its membership to coincide with the annual recruitment and nomination process. Recruitment and selection shall be conducted in accordance with Section III.C-G of this policy.

1. The PAC chair and vice-chair may serve one (1) two (2) year term.

2. The PAC chair and vice-chair may be removed by a majority vote from CalOptima's Board.

J. To establish a nomination ad hoc subcommittee, PAC chair shall ask for three (3) to four (4) Members to serve the ad hoc subcommittee. PAC Members, who are being considered for reappointment, cannot participate in their respective nomination ad hoc subcommittee.

1. Each PAC nomination ad hoc subcommittee shall:

a. Review, evaluate, and select a prospective chair and vice-chair as well as a candidate for each of the open seats, in accordance with Section III. C-G of this policy; and

b. Forward the prospective chair's and vice-chair's name and slate of candidate(s) to the full advisory committee for review and approval.

2. Following approval from the full PAC, the recommended chair and vice chair as well as the slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

K. CalOptima's Board shall review and have final approval for all appointments, reappointments, and chair appointments to PAC.

L. PAC Members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a PAC Member provides notification of an absence to CalOptima staff prior to the PAC meeting. CalOptima staff shall maintain an attendance log of the PAC Members' attendance at PAC meetings. Upon request from the PAC chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the chair of the PAC shall contact any committee Member who has three consecutive unexcused absences.

1. PAC Members' attendance shall be considered as a criterion upon reappointment.

III. PROCEDURE

A. PAC composition

1. The composition of PAC shall reflect the cultural diversity and special needs of the CalOptima population.

2. Specific agency representatives shall serve on the advisory committee as standing Members.

a. The PAC shall include the Director (or his or her designee) of the HCA.

b. HCA representative shall serve as a standing Member and shall not be subject to reapplying.

B. PAC meeting frequency

1. PAC shall meet at least quarterly.

2. PAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed Members shall constitute a quorum.

a. A quorum must be present for any votes to be valid and a quorum consists of half (1/2) total membership plus one.

C. PAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of the CalOptima population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates utilizing a variety of notification methods, which may include, but are not limited to, the following:

a. Outreach to the respective Provider community;

b. Placement of vacancy notices on the CalOptima website; and

c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. During the PAC meeting held in March, the chair or vice-chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice-chair for the upcoming fiscal year. An application is not required for the chair or vice-chair nomination.

D. PAC nomination process

1. The PAC chair or vice-chair shall request three (3) to four (4) Members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee.

   a. At the discretion of the PAC nomination ad hoc subcommittee, a subject matter expert (SME) may be included on the subcommittee to provide consultation and advisement.

2. Prior to the PAC nomination ad hoc subcommittee meeting:

   a. Ad hoc subcommittee Members shall individually evaluate and score the application for each of the prospective candidates using the Application Evaluation Tool.

   b. The ad hoc subcommittee Members shall individually evaluate and select a chair.

3. The ad hoc subcommittee shall convene to discuss and select a candidate for each of the expiring seats by using the findings from the Application Evaluation Tool, the attendance record if relevant, and the prospective candidate's letters of support.

   a. At the discretion of the ad hoc subcommittee, subcommittee Members may contact a prospective candidate's references for additional information and background validation.

E. Term limits and length of term for PAC Members

1. Pursuant to the Board approved Resolution 15-08-06-02, effective July 1, 2015 PAC Members are appointed for three-year terms by the CalOptima Board of Directors with two consecutive term limits.

F. CalOptima shall conduct a special election with a truncated recruitment and nomination process to fill a PAC seat that has been vacated mid-term.

G. PAC selection and approval process for prospective chairs and candidates

1. Upon selection of a recommendation for a chair and vice-chair, as well as the slate of candidates, the ad hoc subcommittee shall forward its recommendation to the PAC for consideration.

2. Following consideration, the PAC's recommendation for a chair and slate of candidates shall be submitted to CalOptima's Board for review and final approval.

3. Following CalOptima's Board approval of PAC's recommendations, the new PAC Members' terms shall be effective July 1.

4. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following PAC meeting.

5. CalOptima shall provide new PAC Members with a new Member orientation.

IV. ATTACHMENT(S)

A. PAC Nomination Position Descriptions
B. PAC Application Evaluation Tool (AET)
C. PAC Application

V. REFERENCE(S)

A. CalOptima Board Resolution 2-14-95
B. CalOptima Board Resolution 06-0707
C. CalOptima Board Resolution 15-0806-02
D. CalOptima Board Resolution 16-0804-02
E. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
02/14/1995	Regular Meeting of the CalOptima Board of Directors
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03/05/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/14/1995	AA.1219	MAC and PAC	Medi-Cal
Revised	07/07/2006	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2011	AA.1219	MAC and PAC	Medi-Cal
Revised	12/01/2013	AA.1219	MAC and PAC	Medi-Cal
Revised	07/01/2015	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	08/04/2016	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

Action	Date	Policy	Policy Title	Program(s)
Revised	08/01/2017	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE
Revised	03/05/2020	AA.1219b	Provider Advisory Committee	Medi-Cal OneCare OneCare Connect PACE

1

IX. GLOSSARY

Term	Definition
Member	An enrollee-beneficiary of a CalOptima program.
Provider	Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by CalOptima to advise its Board of Directors on issues impacting the CalOptima Provider community.
Threshold Language	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

2020 PAC Position Description

Allied Health Services (two seats)

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent; independent, non-hospital, non-network allied providers, such as:
  - Ambulatory surgery centers
  - Audiology
  - Certified Acupuncturist
  - Chronic Dialysis Center
  - Dialysis providers
  - Dispensing Opticians
  - DME providers
  - Emergency Transportation
  - Exempt from Licensure Clinics
  - Family planning centers
  - Hearing Aid Dispensers
  - Home health providers
  - Home infusion providers
  - Hospice
  - Laboratory
  - Non-emergency transportation (NEMT) providers
  - Occupational therapists
  - Physical therapists
  - Podiatrists
  - Portable X-ray Lab
  - Prosthetics
  - Psychologists
  - Radiation therapy centers
  - Radiology
  - Rehabilitation Clinics
  - Respiratory Care Practice
  - Speech Therapist
  - Surgery Clinics
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs

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- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Behavioral/Mental Health Provider

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent providers such as:
  - Licensed Clinical Social Worker (LCSW)
  - Marriage and Family Therapist (MFT)
  - Mental Health Facility
  - Psychologists
  - Psychiatrist
  - Registered Psychiatric Nurse (Psych RN)
  - Multi-Specialty Clinics/Group Practice
  - Community Mental Health Center
  - Board Certified Behavior Analyst-D (BCBA-D)
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Community Health Centers

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent Orange County Community Health Centers:
  - Representing a licensed community clinic

- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Health Network

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent CalOptima contracted Health Networks.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and~~/or~~ CalOptima programs
- Minimum three years of experience working directly for a health network
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Hospital

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent Orange County CalOptima contracted Hospitals.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a hospital provider for CalOptima or representing CalOptima hospital providers directly

- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Long Term Services and Supports

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent providers, such as:
  - Intermediate Care Facility – Developmentally Disabled
  - Intermediate Care Facility – Developmentally Disabled – Nursing
  - Intermediate Care Facility -Developmentally Disabled – Habilitative
  - Level B Adult Subacute
  - Level B Pediatric Subacute
  - Level B Skilled Nursing Facility
  - Nursing Facilities – Intermediate Care Facility Level A
  - Skilled Nursing Facilities
  - Skilled Nursing Facilities/Subacute Level B
  - Adult Day Health Care
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Non-Physician Medical Practitioner Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent such as: nurse practitioners, nurse midwife, physician assistants, registered psychiatric nurse (Psych RN), chiropractors, dentists, optometrists, and others as appropriate
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Professional Degree (e.g. DC, DDS, DNP MMS, OD) required
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Nurse Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent such as; nurses, nurse Practitioner, nurse midwife, registered nurses, registered psychiatric nurse (Psych RN), nurse anesthetist, advanced practice nurse
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s) and local chapters.
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Pharmacy Representative

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent pharmacies and pharmacy associations
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Physician Representative (three positions)

Position Description

- Seats will individually be represented by:
  - Adult Primary Care Physician
  - Pediatric Physician
  - Specialist
- Current experience collaborating with, and ability to reach out, seek input, represent and secure input from their physician constituency as well as their community-based physician professional association. When license or credential is required, applicant must have active CA license/credential as appropriate
- Have an active, unrestricted California medical license and board certification as appropriate
- Membership in appropriate medical professional association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Familiarity with California and federal health care delivery regulatory requirements and mandates
- Familiarity with provider quality and service requirements and risk adjustment factors

- Availability and willingness to attend regular, special and ad hoc PAC meetings and actively contribute
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Safety Net

Position Description

- Current experience collaborating with, and ability to reach out, seek input and represent safety net providers
    - **Safety-Net Provider** means a provider of comprehensive primary care and/or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and Indian Health Service facilities; disproportionate share hospitals; and public, university, rural and children's hospitals.
- When license or credential is required, applicant must have active CA license/credential as appropriate
- Preferred for applicant to belong to appropriate professional/trade association(s)
- Knowledge of managed care systems and CalOptima programs
- Minimum three years of experience as a provider for CalOptima or representing CalOptima providers directly
- Understanding and familiarity with the diverse cultural and/or social environments of Orange County
- Availability and willingness to attend regular, special and ad hoc PAC meetings
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

Health Care Agency Representative (Standing Seat)

Position Description

- Represent the Orange County Health Care Agency
- No term limits
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

PAC Chair

Position Description

- Availability and willingness to attend regular and special PAC meetings
- Facilitate all PAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison between PAC, MAC and the Board of Directors
- Provide PAC Report to CalOptima Board of Directors' monthly meetings
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

PAC Vice-Chair

Position Description

- Availability and willingness to attend regular and special PAC meetings
- Facilitate in absence of the PAC Chair all PAC meetings using standard meeting rules of order
- Demonstrate leadership and openness, enabling meeting attendees to achieve preset meeting goals
- Liaison in absence of the PAC Chair between PAC, MAC and the Board of Directors
- Provide PAC Report to CalOptima Board of Directors' monthly meetings when PAC Chair is unavailable
- Two-year term
- All appointments to the committee will be appointed by the CalOptima Board and are subject to OIG/GSA verification and possible background checks

CalOptima
A Public Agency
Better. Together.

Applicant Name:

Provider Advisory Committee

Position Applying for:

Applicant Evaluation Tool (use one per applicant)

Please rate questions 1 through 5 based on how well the applicant satisfies the following statements where:
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Application is complete and meets minimum qualifications.	YES_____ NO_____	_____
2. Description/explanation of applicant's interest to serve on the PAC plus reasons applicant is qualified to represent constituents and uniquely contribute to the PAC.	1–5	_____
3. List of professional/trade associations related to specific constituency	1–5	_____
4. Ability and specific plan to reach out for input and communication to applicant's constituents including primary professional/trade association(s)	1–5	_____
5. Education and/or licenses	1–3	_____
6. Experience on similar committees or ability to collaborate in a multidisciplinary way	1–3	_____
7. Knowledge/familiarity with California and federal health regulations and requirements	1–5	_____
8. Availability and willingness to attend monthly meetings and serve on subcommittees	1–5	_____
9. Supportive letters of reference (minimum two).	1–2	_____
	Total Possible Points	33
	Total Points Awarded	_____

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PROVIDER ADVISORY COMMITTEE APPLICATION 2020

Instructions: Please answer all questions. You may write or type your answers. Please use a separate sheet if necessary. If you have any questions regarding the application, please call Cheryl Simmons at 714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Cell Phone: _____

City, State, ZIP: _____ Fax: _____

Email: _____ Date: _____

Please submit my application for the following Provider Advisory Committee (PAC) seats:

- ☐ **Allied Health Services Representative (Fulfill remaining term through 2021)**
- ☐ **Community Health Centers Representative**
- ☐ **Hospital Representative**
- ☐ **Physician Representative**
- ☐ **Traditional/Safety Net Representative**

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1. Application is complete and meets minimum qualifications. ☐ Yes ☐ No

2. Please explain why you wish to serve on CalOptima's PAC, describe why you would be a qualified representative and how you might uniquely contribute to the PAC.

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3. List any experience with professional/trade associations within the past five years, especially those related to the constituents that you would represent on the PAC:

   Organization: _____ Dates: _____

   Offices Held: _____

   Organization: _____ Dates: _____

   Offices Held: _____

   Organization: _____ Dates: _____

   Offices Held: _____

   Organization: _____ Dates: _____

   Offices Held: _____

4. Explain your ability and specific plan to reach out for input and communicate with the constituents you would represent on the PAC, including your primary professional/trade association(s).

   _____

   _____

   _____

   _____

5. Education and/or licenses:

   _____

   _____

   _____

6. List similar committees on which you have served or describe your ability to collaborate in a multidisciplinary way.

   _____

   _____

   _____

   _____

7. Are you familiar with California and federal health regulations and requirements? Explain:

_____

_____

_____

8. If selected, are you able to commit to a monthly PAC meeting as well as serve on at least one subcommittee? ☐ Yes ☐ No

Please explain: _____

_____

_____

9. List and attach a minimum of two letters of reference (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

_____ _____

Signature **Date**

Submit this form, along with a biography or résumé and at least two reference letters to:

CalOptima
505 City Parkway West
Orange, CA 92868
Attn: Cheryl Simmons

Phone: **714-347-5785** Fax: **714-571-2479** Email: csimmons@caloptima.org

Application must be received by March 31, 2020 for consideration.

Policy:	AA.1271
Title:	**Whole Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	06/07/2018
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regard to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2)-year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

Back to Agenda Back to Item

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of *CCS* services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of *CCS* services; or

    c. Current CalOptima Members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.F.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group. CalOptima shall reimburse eligible expenses associated with attending the statewide stakeholder advisory group quarterly meetings in accordance with CalOptima Policy GA.5004: Travel Policy.

G. Stipends

1. CalOptima may provide a reasonable per diem payment of up to $50 per meeting to a Member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the Member or family representative, including type and value, and shall provide such log to DHCS upon request.

2. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an bi-annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this policy.

1. The WCM FAC chair and vice chair may serve ~~two~~ one (~~2~~1) ~~consecutive one~~ two (~~1~~2) year term~~s~~.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair or vice chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

   b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee Application
B. Whole Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee Application
D. Whole Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Policy GA.5004: Travel Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/19/2019	Department of Health Care Services (DHCS)
09/07/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
05/02/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	TBD	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the ~~Group~~ Population Needs Assessment (PG~~G~~NA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Policy:	AA.1271
Title:	**Whole Child Model Family Advisory Committee**
Department:	Customer Service
Section:	Not Applicable
Interim CEO Approval:	
Effective Date:	06/07/2018
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole-Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole-Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regard to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC Members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2)-year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

Back to Agenda Back to Item

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of *CCS* services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of *CCS* services; or

    c. Current CalOptima Members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

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3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

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    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

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J. On an bi-annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this policy.

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2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair or vice chair shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

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    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this policy; and

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M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, for any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair or vice chair shall contact any committee member who has three (3) consecutive unexcused absences.

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2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nomination's ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

   a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

   a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

   b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

   c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

   a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENT(S)

A. Whole Child Model Member Advisory Committee Application
B. Whole Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole Child Model Community Advisory Committee Application
D. Whole Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. CalOptima Policy GA.5004: Travel Policy
E. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
07/19/2019	Department of Health Care Services (DHCS)
09/07/2018	Department of Health Care Services (DHCS)

VII. BOARD ACTION(S)

Date	Meeting
11/02/2017	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
05/02/2019	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy #	Policy Title	Program(s)
Effective	06/07/2018	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	05/02/2019	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative
Revised	TBD	AA.1271	Whole Child Model Family Advisory Committee	Medi-Cal Administrative

IX. GLOSSARY

Term	Definition
California Children's Services Program (CCS)	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole-Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).
Whole-Child Model (WCM)	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-347-5785**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
☐ CalOptima members age 18–21 who are current recipients of CCS services; or
☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Five seats are available with a term beginning July 1, 2020, through June 30, 2022

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:
Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TTY users can call toll-free at **1-800-735-2929**.

Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TTY users can call toll-free **1-800-735-2929**.

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole-Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal Health Insurance Portability and Accountability Act (HIPAA), Privacy Regulations require that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): **Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.**
Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for.**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TTY users can call toll-free **1-800-735-2929**.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole-Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the HIPAA, and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of this authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TTY users can call toll-free at **1-800-735-2929**.

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Applicant Name:

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat:
Authorized Family Member

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	_____
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	_____
Include relevant experience with these populations	1–5	_____
3. Knowledge or experience with California Children's Services	1–5	_____
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	30
	Total Points Awarded	_____

_____
Name of Evaluator

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Whole-Child Model Family Advisory Committee (WCM FAC)
Community Application Fiscal Year 2020

Instructions: Please answer all questions. You may handwrite or type your answers.
Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-347-5785.

Name: _____ Work Phone: _____

Address: _____ Mobile Phone: _____

City, State ZIP: _____ Fax Number: _____

Date: _____ Email: _____

Please see the eligibility criteria below:

The WCM FAC is currently recruiting for the following seat:

☐ Community-based organizations

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

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2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

4. Please explain why you wish to serve on the WCM FAC:

5. Describe why you would be a qualified representative for service on the WCM FAC:

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City, State ZIP: _____	City, State ZIP: _____
Phone: _____	Phone: _____
Email: _____	Email: _____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Cheryl Simmons
Email: mailto:csimmons@caloptima.org
For questions, call **1-714-347-5785**

Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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Applicant Name:

WCM Family Advisory Committee Community Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat:

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
Name of Evaluator _____	Total Points Awarded	_____

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Board of Directors Meeting
August 6, 2020

Member Advisory Committee Update

June 11, 2020 MAC Meeting

At the June 11, 2020 Member Advisory Committee (MAC) meeting, members approved a recommendation to appoint Steve Thronson to the MAC as the Orange County Health Care Agency Representative.

The MAC also approved its FY 2019-20 Accomplishments, noting that MAC members contributed at least 232 official hours to CalOptima during FY 2019-20, including MAC meetings, ad hoc meetings, and Board meetings which is equivalent to 29 full work days during the fiscal year.

Ladan Khamseh, Chief Operating Officer, provided an update on CalOptima's telephonic outreach on COVID-19 to CalOptima members. Ms. Khamseh also noted that CalOptima has selected a new text messaging vendor that will send text messages with information on services and programs offered to CalOptima members with cellular phones.
Jonathan T. Megerian, M.D., a board-certified Pediatric Neurologist at Children's Hospital of Orange County (CHOC), presented on CHOC's new Thompson Autism Center. This presentation solicited many questions from MAC members, as Dr. Megerian described the benefits and services that are available at this new state-of-the-art center.

MAC received updates on COVID-19 from Emily Fonda, M.D., Deputy Chief Medical Officer. In addition, TC Roady, Director of Regulatory Affairs, provided the MAC with a Federal and State Legislative update and Mary Botts, Manager, Enterprise Analytics, provided an update on Members Experiencing Homelessness.

Once again, the MAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the MAC's current activities.

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Board of Directors Meeting
August 6, 2020

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)
Member Advisory Committee Update

At the June 25, 2020 OneCare Connect Member Advisory Committee (OCC MAC) meeting, the members approved the OCC MAC FY 2020-21 meeting schedule and FY 2019-20 Committee Accomplishments. The members also approved a recommended slate of new OCC MAC candidates.

Richard Sanchez, Interim Chief Executive Officer, reported on the State Budget and the CalOptima FY 2020-21 budget. Mr. Sanchez also noted that new Board members will be seated at the August 6, 2020 meeting.

David Ramirez, M.D., Chief Medical Officer, provided the members with an update on CalOptima's quality audit results. Dr. Ramirez also notified the members that CalOptima is contracting with a new texting vendor and this technology will be used to reach out to members.

OCC MAC received updates on COVID-19 by Emily Fonda, M.D., Deputy Chief Medical Officer, a Federal and State Legislative Update by TC Roady, Director, Regulatory Affairs, and a quarterly Ombudsman Report by OCC MAC member Sara Lee, Sr. Attorney with California Legal Aid Services. OCC MAC members also received an update on Members Experiencing Homelessness from Mary Botts, Manager, Enterprise Analytics.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
August 6, 2020

Whole-Child Model Family Advisory Committee (WCM FAC) Update

June 23, 2020 WCM FAC Meeting

At the June 23, 2020 Whole-Child Member Family Advisory Committee (WCM FAC) the members in approving the WCM FAC's FY 2020-21 meeting schedule and considered and approved a recommended slate of candidates and approved a recommendation to extend the Chair and Vice Chair term lengths.

Richard Sanchez, Interim Chief Executive Officer, provided an updated to the WCM FAC members on the California State Budget and the CalOptima FY 2020-21 budget. Mr. Sanchez noted that he would keep the committee apprised of any future changes to both budgets. Mr. Sanchez also noted that new Board members will be seated at the August 6, 2020 meeting.

Ladan Khamseh, Chief Operating Officer, noted the one-year anniversary for CalOptima's implementation of the Whole-Child Model program. Ms. Khamseh also updated the members on Medi-Cal eligibility for Whole-Child Model and newborns that might be treated in the Newborn Intensive Care Unit (NICU).

David Ramirez, Chief Medical Officer, updated the WCM FAC members on the Pharmacy Carve-Out and noted that the pharmacy benefit that members currently receive through CalOptima will transition to the State's vendor effective January 1, 2021. Dr. Ramirez also noted that CalOptima continues to advocate on behalf of the Whole-Child Model through the Department of Health Care Services Whole-Child Model Advisory Group to insure a smooth transition.

WCM FAC received updates on COVID-19 by Emily Fonda, M.D., Deputy Chief Medical Officer, and an update on Continuity of Care from Dr. Thanh-Tam Nguyen, M.D., Medical Director for the Whole-Child Model Program.

The WCM FAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the WCM FAC's current activities.

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Board of Directors Meeting
August 6, 2020

Provider Advisory Committee (PAC) Update

June 11, 2020 PAC Meeting

On June 11, 2020, the Provider Advisory Committee (PAC) held its monthly meeting via GoTo Webinar and welcomed new Allied Health Representatives Jennifer Birdsall, Ph.D., and Peter Korchin. They were appointed by the Board to fulfill the remaining terms at the June 4, 2020 Board meeting. All PAC seats are now filled.

PAC members approved the Committee's 2019-20 Accomplishments, with Chair Nishimoto noting that members had participated in at least three ad hoc subcommittees and dedicated approximately 276 hours or the equivalent of nearly 35 business days to PAC endeavors.

Richard Sanchez, Interim Chief Executive Officer, provided an overview of CalOptima's FY 2020-21 budget, which was approved on June 4, 2020. He also discussed Governor Newsom's May Revision of the State budget for FY 2020-21. He also updated the Committee on changes in the composition of the Board effective in August.

Ladan Khamseh, Chief Operating Officer, discussed the provider and network contract renewals that would take effect on July 1, 2020. She also discussed how CalOptima is continuing to encourage internal staff to maintain social distancing and the wearing of face masks.

David Ramirez, M.D., Chief Medical Officer, discussed the Department of Health Care Services (DHCS) and Centers for Medicare and Medicaid (CMS) regulatory changes, which include the delay of the CalAIM program and DHCS's request that the California Medicaid 1115 Waiver be extended for an additional year.

Nancy Huang, Chief Financial Officer, provided the PAC with an FY 2020-21 Enrollment and Budget Highlights presentation. She noted that CalOptima is forecasting an overall increase of 7.4% in membership in the upcoming fiscal year.

PAC also received a COVID-19 update, a CalOptima Members Experiencing Homelessness Update, and a Federal and State Legislative update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to provide input and updates on the PAC's activities.

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NKF TEAM INTRODUCTION
& REAL ESTATE PROCESS

Prepared for August 6, 2020 Board Meeting

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Newmark
Knight Frank

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CORE TEAM STATS & EXPERIENCE

JUSTIN HODGDON
Project Manager

DAVID KLUTH
Account Manager

MAI HU
Assistant Account Manager
Documentation & Process Management

BERICK TREIDLER
Highest & Best Use (Development)

JEFF MOLITOR
Regional Workplace Manager

LARRY WASS
Director of Financial Services

1.3 MILLION
SQUARE FEET OF OC TRANSACTIONS

$2 BILLION
CORE TEAM TRANSACTIONS

OVER 40%
OC CAPITAL MARKET SHARE

30+
LAND USE VALUATIONS (2019)

1 MILLION SF +
DEVELOPMENT & ENTITLEMENTS SQUARE FOOTAGE

NEO GENOMICS

AltaMed

Dignity Health

goodwill orange county

CONIFER HEALTH SOLUTIONS

CSU The California State University

NKF STATS

$3.3 BILLION
ANNUAL REVENUE

18,000+
EMPLOYEES

480+
OFFICES

58
COUNTRIES

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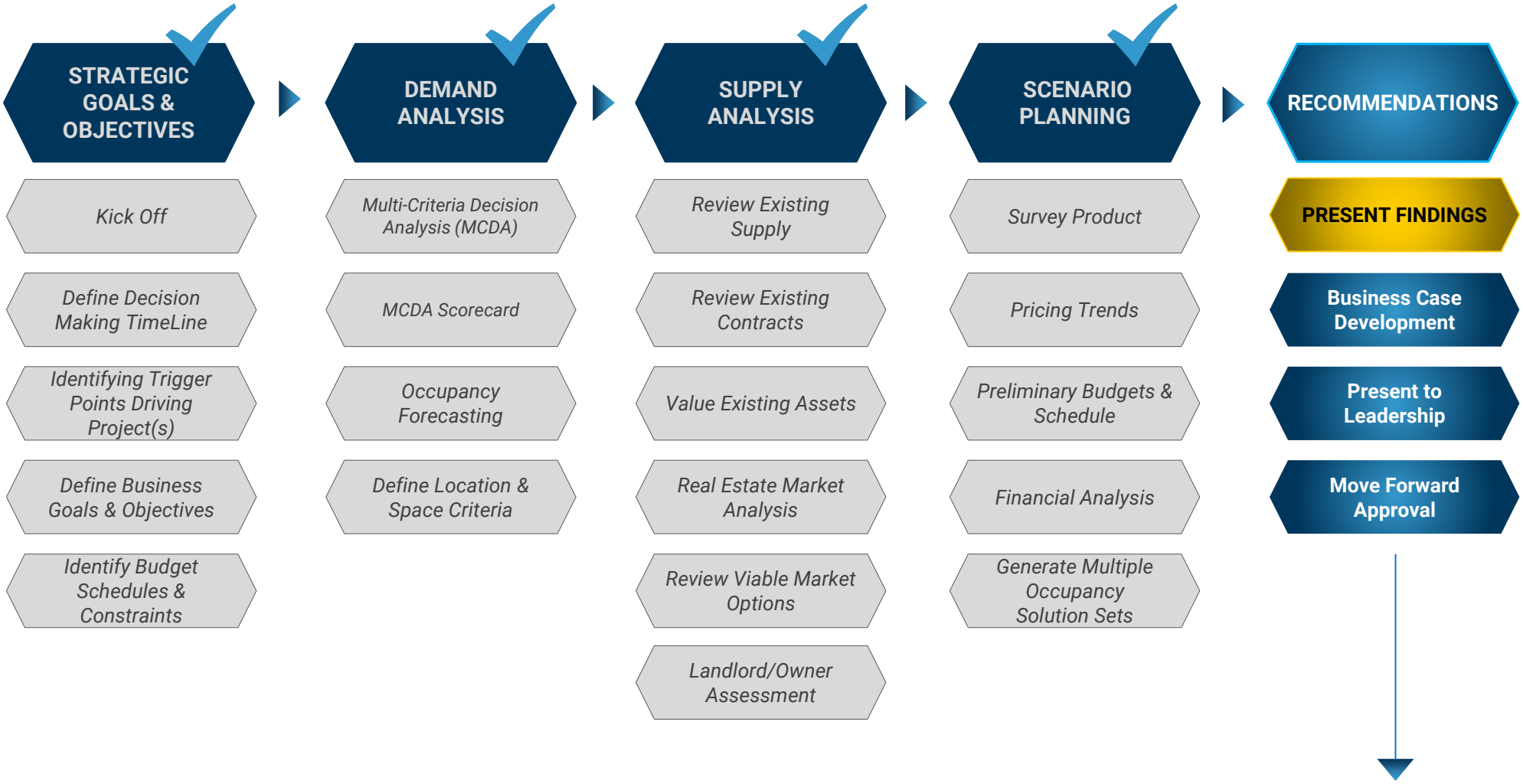
WORKPLAN



IMPLEMENTATION PHASE

Project Timeline ▶ **Engage Market** ▶ **Negotiations** ▶ **Analysis** ▶ **Documentation** ▶ **Presentations & Approvals** ▶ **Execute** ▶ **Construct** ▶ **OCCUPY**

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PROCESSES IN MOTION

- HQ
  - Validate growth projections and expansion requirements
  - Analyze short & long term parking solutions
  - Continue to work with CalOptima team to analyze alternatives and determine next steps

- Development Agreement
  - Development Agreement expires fourth quarter of 2020
  - Staff has already sent the extension request to City of Orange in June 2020
  - Assist management team to explore and evaluate future options of Development Agreement

- PACE
  - Market conditions and relocation options being considered
  - Extension negotiations underway
  - Lease expires 12/31/2021

- Next Steps – Review findings with CalOptima staff

- Q&A

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Presented By:

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LARRY WASS
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Newmark Knight Frank

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Financial Summary

May 2020

Board of Directors Meeting

August 6, 2020

Nancy Huang

Chief Financial Officer

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FY 2019-20: Consolidated Enrollment

May 2020 MTD

Overall enrollment was 744,831 members

- Actual higher than budget 8,874 or 1.2%
  - Medi-Cal favorable to budget 8,917 or 1.2%
    - Temporary Assistance for Needy Families (TANF) favorable variance of 12,703
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,638
    - Long-Term Care (LTC) favorable variance of 88
    - Medi-Cal Expansion (MCE) unfavorable variance of 3,281
    - Whole Child Model (WCM) unfavorable variance of 2,231
  - OneCare Connect favorable to budget 93 or 0.7%
  - OneCare unfavorable to budget 113 or 7.4%
  - PACE unfavorable to budget 23 or 5.5%
- 7,677 increase or 1.0% from April
    - Medi-Cal increase of 7,881
    - OneCare Connect decrease of 239
    - OneCare increase of 40
    - PACE decrease of 5

FY 2019-20: Consolidated Enrollment (cont.)

May 2020 YTD

Overall enrollment was 8,121,456 member months

- Actual lower than budget 66,042 or 0.8%
  - Medi-Cal unfavorable to budget 66,767 or 0.8%
    - MCE unfavorable variance of 79,241
    - WCM unfavorable variance of 17,068
    - TANF favorable variance 15,012
    - SPD favorable variance of 13,581
    - LTC favorable variance of 948
  - OneCare Connect favorable to budget 1,193 or 0.8%
  - OneCare unfavorable to budget 461 or 2.8%
  - PACE unfavorable to budget 7 or 0.2%

FY 2019-20: Consolidated Revenues

May 2020 MTD

- Actual lower than budget $12.7 million or 4.3%
  - ➢ Medi-Cal unfavorable to budget $14.9 million or 5.6%
    - o Favorable volume variance of $3.3 million
    - o Unfavorable price variance of $18.2 million
      - $8.6 million of Behavioral Health Treatment (BHT) revenue
      - $5.8 million of revenue from initial estimates of May Revise impact from the Department of Health Care Services (DHCS)
      - $3.3 million of WCM revenue
  - ➢ OneCare Connect favorable to budget $2.1 million or 9.0%
    - o Favorable volume variance of $0.2 million
    - o Favorable price variance of $2.0 million
      - $1.4 million of revenue from calendar year (CY) 2020 mid-year Hierarchical Condition Category (HCC) reconciliation

FY 2019-20: Consolidated Revenues (cont.)

May 2020 MTD (cont.)

- OneCare favorable to budget $0.2 million 10.6%
  - Unfavorable volume variance of $0.1 million
  - Favorable price variance of $0.3 million
- PACE unfavorable to budget $88.9 thousand or 2.7%
  - Unfavorable volume variance of $178.0 thousand
  - Favorable price variance of $89.1 thousand

FY 2019-20: Consolidated Revenues (cont.)

May 2020 YTD

- Actual higher than budget $243.0 million or 7.4%
  - ➢ Medi-Cal favorable to budget $224.9 million or 7.6%
    - o Unfavorable volume variance of $24.6 million
    - o Favorable price variance of $249.5 million
      - $195.3 million of Directed Payments (DP) revenue
      - $75.0 million of Coordinated Care Initiative (CCI) revenue due to updated rate and member mix
      - $26.5 million of LTC revenue from non-LTC categories of aid
      - $9.6 million of BHT revenue
      - Offset by $19.8 million of revenue from initial estimates of May Revise impact and updated rates from DHCS
      - $41.3 million of WCM revenue

FY 2019-20: Consolidated Revenues (cont.)

May 2020 YTD (cont.)

- OneCare Connect favorable to budget $21.1 million or 8.0%
  - Favorable volume variance of $2.0 million
  - Favorable price variance of $19.0 million
    - $9.4 million from CY 2019 and 2020 HCC reconciliation
    - $6.6 million of Part D revenue
    - $3.7 million of CY 2015 through 2018 estimated Centers for Medicare & Medicaid Services (CMS) HCC records adjustment
- OneCare unfavorable to budget $4.4 million or 24.2%
  - Unfavorable volume variance of $0.5 million
  - Unfavorable price variance of $3.9
- PACE favorable to budget $1.5 million or 4.5%
  - Unfavorable volume variance of $0.1 million
  - Favorable price variance of $1.5 million

FY 2019-20: Consolidated Medical Expenses

May 2020 MTD

- Actual lower than budget $14.3 million or 5.0%
  - ➢ Medi-Cal favorable variance of $11.8 million or 4.6%
    - o Unfavorable volume variance of $3.2 million
    - o Favorable price variance of $15.0 million
      - Facilities Claims favorable variance of $13.8 million
      - Professional Claims favorable variance of $3.8 million
      - Reinsurance & Other favorable variance of $2.4 million
      - Medical Management favorable variance of $2.0 million
      - MLTSS unfavorable variance of $3.3 million
      - Prescription Drugs unfavorable variance of $3.2 million
  - ➢ OneCare Connect favorable variance of $1.9 million or 8.1%
    - o Unfavorable volume variance of $0.2 million
    - o Favorable price variance of $2.0 million

FY 2019-20: Consolidated Medical Expenses (cont.)

May 2020 MTD (cont.)

- OneCare favorable variance of $0.3 million or 15.8%
  - Favorable volume variance of $0.1 million
  - Favorable price variance of $0.1 million
- PACE favorable variance of $0.4 million or 14.0%
  - Favorable volume variance of $0.2 million
  - Favorable price variance of $0.2 million

FY 2019-20: Consolidated Medical Expenses (cont.)

May 2020 YTD

- Actual higher than budget $251.4 million or 8.1%
  - ➢ Medi-Cal unfavorable variance of $244.3 million or 8.7%
    - o Favorable volume variance of $23.4 million
    - o Unfavorable price variance of $267.7 million
      - Reinsurance and Other unfavorable variance of $178.7 million due to $195.5 million of DP, offset by favorable variance in Homeless Health Initiative
      - Professional Claims unfavorable variance of $32.9 million
      - Prescription Drugs unfavorable variance of $26.1 million
      - MLTSS unfavorable variance of $21.3 million
      - Facilities Claims unfavorable variance of $19.1 million
      - Offset by Medical Management favorable variance of $13.3 million

FY 2019-20: Consolidated Medical Expenses (cont.)

May 2020 YTD (cont.)

- OneCare Connect unfavorable variance of $11.4 million or 4.4%
  - Unfavorable volume variance of $2.0 million
  - Unfavorable price variance of $9.4 million
- OneCare favorable variance of $3.2 million or 18.4%
  - Favorable volume variance of $0.5 million
  - Favorable price variance of $2.7 million
- PACE favorable variance of $1.0 million or 3.7%
  - Favorable volume variance of $47.3 thousand
  - Favorable price variance of $992.2 thousand

Medical Loss Ratio (MLR)

- May 2020 MTD: Actual: 96.0% Budget: 96.7%
- May 2020 YTD: Actual: 95.9% Budget: 95.3%

FY 2019-20: Consolidated Administrative Expenses

May 2020 MTD

- Actual lower than budget $2.0 million or 14.8%
  - Salaries, wages and benefits: favorable variance of $0.3 million
  - Other categories: favorable variance of $1.7 million

May 2020 YTD

- Actual lower than budget $19.3 million or 13.4%
  - Salaries, wages and benefits: favorable variance of $7.8 million
  - Other categories: favorable variance of $11.5 million

Administrative Loss Ratio (ALR)

- May 2020 MTD: Actual: 4.1% Budget: 4.6%
- May 2020 YTD: Actual: 3.6% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.8% YTD

FY 2019-20: Change in Net Assets

May 2020 MTD

- $4.5 million change in net assets
- $7.1 million favorable to budget
  - Lower than budgeted revenue of $12.7 million
  - Lower than budgeted medical expenses of $14.3 million
  - Lower than budgeted administrative expenses of $2.0 million
  - Higher than budgeted investment and other income of $3.4 million

May 2020 YTD

- $59.2 million change in net assets
- $37.0 million favorable to budget
  - Higher than budgeted revenue of $243.0 million
  - Higher than budgeted medical expenses of $251.4 million
  - Lower than budgeted administrative expenses of $19.3 million
  - Higher than budgeted investment and other income of $26.0 million

Enrollment Summary: May 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,799	66,504	295	0.4%	Aged	726,552	724,306	2,246	0.3%
506	615	(109)	(17.7%)	BCCTP	5,792	6,765	(973)	(14.4%)
44,970	43,518	1,452	3.3%	Disabled	492,916	480,608	12,308	2.6%
282,075	273,956	8,119	3.0%	TANF Child	3,099,632	3,088,065	11,567	0.4%
87,927	83,343	4,584	5.5%	TANF Adult	946,214	942,769	3,445	0.4%
3,492	3,404	88	2.6%	LTC	38,392	37,444	948	2.5%
232,639	235,920	(3,281)	(1.4%)	MCE	2,511,052	2,590,293	(79,241)	(3.1%)
10,709	12,940	(2,231)	(17.2%)	WCM	125,272	142,340	(17,068)	(12.0%)
729,117	**720,200**	**8,917**	**1.2%**	**Medi-Cal Total**	**7,945,823**	**8,012,590**	**(66,767)**	**(0.8%)**
13,912	**13,819**	**93**	**0.7%**	**OneCare Connect**	**155,370**	**154,177**	**1,193**	**0.8%**
1,404	**1,517**	**(113)**	**(7.4%)**	**OneCare**	**16,100**	**16,561**	**(461)**	**(2.8%)**
398	**421**	**(23)**	**(5.5%)**	**PACE**	**4,163**	**4,170**	**(7)**	**(0.2%)**
744,831	**735,957**	**8,874**	**1.2%**	**CalOptima Total**	**8,121,456**	**8,187,498**	**(66,042)**	**(0.8%)**

Financial Highlights: May 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
744,831	735,957	8,874	1.2%	Member Months	8,121,456	8,187,498	(66,042)	(0.8%)
284,150,040	296,829,953	(12,679,914)	(4.3%)	Revenues	3,512,145,068	3,269,123,250	243,021,819	7.4%
272,735,437	287,082,167	14,346,730	5.0%	Medical Expenses	3,367,724,830	3,116,351,440	(251,373,390)	(8.1%)
11,536,552	13,543,826	2,007,274	14.8%	Administrative Expenses	125,001,224	144,337,846	19,336,622	13.4%
(121,950)	**(3,796,040)**	**3,674,091**	**96.8%**	**Operating Margin**	**19,419,014**	**8,433,964**	**10,985,050**	**130.2%**
4,656,393	1,250,000	3,406,393	272.5%	Non Operating Income (Loss)	39,764,261	13,750,000	26,014,261	189.2%
4,534,443	**(2,546,040)**	**7,080,483**	**278.1%**	**Change in Net Assets**	**59,183,275**	**22,183,964**	**36,999,311**	**166.8%**
96.0%	96.7%	0.7%		Medical Loss Ratio	95.9%	95.3%	(0.6%)	
4.1%	4.6%	0.5%		Administrative Loss Ratio	3.6%	4.4%	0.9%	
(0.0%)	(1.3%)	1.2%		Operating Margin Ratio	0.6%	0.3%	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)	3.8%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Consolidated Performance Actual vs. Budget: May 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(3.8)	(2.6)	(1.2)	Medi-Cal	18.7	21.4	(2.6)
2.8	(1.3)	4.1	OCC	(1.8)	(13.9)	12.1
0.3	(0.1)	0.4	OneCare	(2.3)	(1.2)	(1.1)
0.6	0.3	0.3	PACE	4.8	2.2	2.6
(0.1)	**(3.8)**	**3.7**	**Operating**	**19.4**	**8.4**	**11.0**
4.7	1.3	3.4	Inv./Rental Inc, MCO tax	39.8	13.8	26.0
4.7	**1.3**	**3.4**	**Non-Operating**	**39.8**	**13.8**	**26.0**
4.5	**(2.5)**	**7.1**	**TOTAL**	**59.2**	**22.2**	**37.0**

Consolidated Revenue & Expense: May 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	485,769	232,639	10,709	729,117	13,912	1,404	398	744,831
REVENUES								
Capitation Revenue	127,323,854	$ 105,930,947	$ 19,983,152	$ 253,237,952	$ 25,946,014	$ 1,796,622	$ 3,169,451	$ 284,150,040
Total Operating Revenue	127,323,854	105,930,947	19,983,152	253,237,952	25,946,014	1,796,622	3,169,451	284,150,040
MEDICAL EXPENSES								
Provider Capitation	41,125,140	46,304,978	7,513,741	94,943,859	10,379,466	539,349		105,862,674
Facilities	19,080,132	13,313,697	3,678,096	36,071,926	2,323,675	255,308	662,731	39,313,641
Professional Claims	12,869,384	6,344,624	1,074,004	20,288,013	663,079	46,867	525,465	21,523,424
Prescription Drugs	18,981,760	23,369,833	6,033,922	48,385,515	5,730,870	439,490	283,564	54,839,439
MLTSS	37,117,089	2,804,221	1,761,468	41,682,778	1,236,998	48,203	5,251	42,973,229
Medical Management	2,085,416	1,317,889	276,089	3,679,394	949,034	26,678	746,402	5,401,508
Quality Incentives	914,256	466,023	139,830	1,520,109	206,720		4,975	1,731,804
Reinsurance & Other	436,587	433,263	15,290	885,140	8,114		196,465	1,089,719
Total Medical Expenses	132,609,764	94,354,528	20,492,442	247,456,733	21,497,956	1,355,895	2,424,854	272,735,437
Medical Loss Ratio	104.2%	89.1%	102.5%	97.7%	82.9%	75.5%	76.5%	96.0%
GROSS MARGIN	**(5,285,910)**	**11,576,419**	**(509,289)**	**5,781,219**	**4,448,059**	**440,727**	**744,597**	**11,414,602**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,733,341	765,889	90,694	126,753	7,716,677
Professional fees				180,608	14,613	15,000	123	210,344
Purchased services				876,378	110,547	7,827	13,288	1,008,039
Printing & Postage				346,023	173,297	5,824	50	525,194
Depreciation & Amortization				313,333			2,079	315,413
Other expenses				1,404,402	37,910		3,552	1,445,864
Indirect cost allocation & Occupancy				(278,570)	552,199	37,170	4,221	315,021
Total Administrative Expenses				9,575,516	1,654,454	156,515	150,067	11,536,552
Admin Loss Ratio				3.8%	6.4%	8.7%	4.7%	4.1%
INCOME (LOSS) FROM OPERATIONS				(3,794,296)	2,793,605	284,212	594,530	(121,950)
INVESTMENT INCOME								4,042,226
TOTAL MCO TAX				604,300				604,300
TOTAL GRANT INCOME				9,225				9,225
OTHER INCOME				642				642
CHANGE IN NET ASSETS				**$ (3,180,130)**	**$ 2,793,605**	**$ 284,212**	**$ 594,530**	**$ 4,534,443**
BUDGETED CHANGE IN NET ASSETS				(2,611,059)	(1,311,471)	(132,425)	258,915	(2,546,040)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (569,071)	$ 4,105,076	$ 416,637	$ 335,615	$ 7,080,483

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Consolidated Revenue & Expense: May 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,309,499	2,511,052	125,272	7,945,823	155,370	16,100	4,163	8,121,456
REVENUES								
Capitation Revenue	1,708,436,053	$ 1,227,636,189	$ 244,655,588	$ 3,180,727,830	$ 283,946,427	$ 13,645,557	$ 33,825,254	$ 3,512,145,068
Total Operating Revenue	1,708,436,053	1,227,636,189	244,655,588	3,180,727,830	283,946,427	13,645,557	33,825,254	3,512,145,068
MEDICAL EXPENSES								
Provider Capitation	430,459,526	485,043,452	107,347,012	1,022,849,990	125,837,091	3,259,333		1,151,946,413
Facilities	264,219,037	226,227,804	56,148,635	546,595,476	40,686,958	4,307,256	7,294,114	598,883,804
Ancillary	-	-	-	-	-	-	-	-
Professional Claims	192,597,320	77,167,373	15,804,401	285,569,095	8,260,526	553,711	6,245,969	300,629,301
Prescription Drugs	215,149,462	227,526,805	62,865,901	505,542,169	63,151,497	5,531,129	2,733,055	576,957,848
MLTSS	378,802,157	28,970,050	18,286,483	426,058,690	14,600,943	278,848	351,092	441,289,573
Medical Management	23,339,544	13,995,249	2,816,371	40,151,163	11,882,859	444,645	8,090,636	60,569,303
Quality Incentives	10,429,848	5,286,962	1,561,838	17,278,648	2,218,500		206,247	19,703,396
Reinsurance & Other	123,213,917	90,183,254	346,939	213,744,110	1,780,445		2,220,637	217,745,192
Total Medical Expenses	1,638,210,812	1,154,400,949	265,177,580	3,057,789,340	268,418,818	14,374,921	27,141,751	3,367,724,830
Medical Loss Ratio	95.9%	94.0%	108.4%	96.1%	94.5%	105.3%	80.2%	95.9%
GROSS MARGIN	**70,225,241**	**73,235,241**	**(20,521,991)**	**122,938,490**	**15,527,610**	**(729,364)**	**6,683,503**	**144,420,238**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				71,548,956	7,991,693	761,948	1,555,697	81,858,293
Professional fees				2,232,548	491,486	204,371	1,753	2,930,157
Purchased services				9,441,376	1,465,323	135,776	101,216	11,143,691
Printing & Postage				3,872,117	878,674	56,013	101,347	4,908,151
Depreciation & Amortization				3,840,030			22,919	3,862,950
Other expenses				16,162,719	358,086	2,472	42,979	16,566,257
Indirect cost allocation & Occupancy				(2,870,562)	6,132,949	422,146	47,192	3,731,725
Total Administrative Expenses				104,227,185	17,318,210	1,582,727	1,873,102	125,001,224
Admin Loss Ratio				3.3%	6.1%	11.6%	5.5%	3.6%
INCOME (LOSS) FROM OPERATIONS				18,711,305	(1,790,601)	(2,312,091)	4,810,401	19,419,014
INVESTMENT INCOME								40,532,225
TOTAL MCO TAX				(739,918)				(739,918)
TOTAL GRANT INCOME				(29,248)				(29,248)
OTHER INCOME				1,204				1,204
CHANGE IN NET ASSETS				**$ 17,943,342**	**$ (1,790,601)**	**$ (2,312,091)**	**$ 4,810,401**	**$ 59,183,275**
BUDGETED CHANGE IN NET ASSETS				21,356,621	(13,871,998)	(1,221,884)	2,171,225	22,183,964
VARIANCE TO BUDGET - FAV (UNFAV)				$ (3,413,279)	$ 12,081,397	$ (1,090,207)	$ 2,639,176	$ 36,999,311

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Balance Sheet: As of May 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$428,367,826	Accounts Payable	$63,793,092
Investments	586,321,744	Medical Claims liability	787,943,508
Capitation receivable	412,452,692	Accrued Payroll Liabilities	12,814,321
Receivables - Other	38,549,431	Deferred Revenue	116,363,733
Prepaid expenses	7,281,766	Deferred Lease Obligations	163,581
		Capitation and Withholds	139,875,131
Total Current Assets	**1,472,973,459**	**Total Current Liabilities**	**1,120,953,366**
Capital Assets			
Furniture & Equipment	39,639,800		
Building/Leasehold Improvements	8,530,915		
505 City Parkway West	51,616,611		
	99,787,325		
Less: accumulated depreciation	(52,746,333)		
Capital assets, net	47,040,993	Other (than pensions) post employment benefits liability	26,050,269
Other Assets		Net Pension Liabilities	23,610,599
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,170,614,235**
Cash and Cash Equivalents	4,488,574		
Long-term Investments	578,654,827	Deferred Inflows	
Total Board-designated Assets	583,143,401	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	641,642,314	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,161,656,766**	TNE	100,383,991
		Funds in Excess of TNE	894,342,154
Deferred Outflows		**TOTAL NET POSITION**	994,726,145
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,172,747,215**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,172,747,215**

Board Designated Reserve and TNE Analysis
As of May 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	159,582,879				
	Tier 1 - MetLife	158,406,054				
	Tier 1 - Wells Capital	158,967,813				
Board-designated Reserve		476,956,747	313,957,380	491,532,253	162,999,367	(14,575,506)
TNE Requirement	Tier 2 - MetLife	106,186,654	100,383,991	100,383,991	5,802,663	5,802,663
	Consolidated:	**583,143,401**	**414,341,371**	**591,916,244**	**168,802,030**	**(8,772,843)**
	Current reserve level	*1.97*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

May 2020

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CalOptima - Consolidated
Financial Highlights
For the Eleven Months Ended May 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Budget	% Budget		Actual	Budget	$ Budget	% Budget
744,831	735,957	8,874	1.2%	Member Months	8,121,456	8,187,498	(66,042)	(0.8%)
284,150,040	296,829,953	(12,679,914)	(4.3%)	Revenues	3,512,145,068	3,269,123,250	243,021,819	7.4%
272,735,437	287,082,167	14,346,730	5.0%	Medical Expenses	3,367,724,830	3,116,351,440	(251,373,390)	(8.1%)
11,536,552	13,543,826	2,007,274	14.8%	Administrative Expenses	125,001,224	144,337,846	19,336,622	13.4%
(121,950)	**(3,796,040)**	**3,674,091**	**96.8%**	**Operating Margin**	**19,419,014**	**8,433,964**	**10,985,050**	**130.2%**
4,656,393	1,250,000	3,406,393	272.5%	Non Operating Income (Loss)	39,764,261	13,750,000	26,014,261	189.2%
4,534,443	**(2,546,040)**	**7,080,483**	**278.1%**	**Change in Net Assets**	**59,183,275**	**22,183,964**	**36,999,311**	**166.8%**
96.0%	96.7%	0.7%		Medical Loss Ratio	95.9%	95.3%	(0.6%)	
4.1%	4.6%	0.5%		Administrative Loss Ratio	3.6%	4.4%	0.9%	
(0.0%)	(1.3%)	1.2%		Operating Margin Ratio	0.6%	0.3%	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)	3.8%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

CalOptima
Financial Dashboard
For the Eleven Months Ended May 31, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	729,117	720,200	8,917	1.2%
OneCare Connect	13,912	13,819	93	0.7%
OneCare	1,404	1,517	(113)	(7.4%)
PACE	398	421	(23)	(5.5%)
Total	744,831	735,957	8,874	1.2%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (3,180)	$ (2,611)	$ (569)	(21.8%)
OneCare Connect	2,794	(1,311)	4,105	313.1%
OneCare	284	(132)	417	315.2%
PACE	595	259	336	129.7%
505 Bldg.	-	-	-	0.0%
Investment Income	4,042	1,250	2,792	223.4%
Total	$ 4,534	$ (2,546)	$ 7,080	278.1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.7%	96.7%	(1.0)
OneCare Connect	82.9%	98.2%	15.4
OneCare	75.5%	99.2%	23.7

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 9,576	$ 11,488	$ 1,913	16.6%
OneCare Connect	1,654	1,730	75	4.4%
OneCare	157	146	(11)	(7.2%)
PACE	150	180	30	16.5%
Total	$ 11,537	$ 13,544	$ 2,007	14.8%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,081	1,183	102
OneCare Connect	199	211	12
OneCare	10	9	(1)
PACE	81	94	13
Total	1,371	1,497	126

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	674	609	65
OneCare Connect	70	66	4
OneCare	137	163	(26)
PACE	5	5	0
Total	886	842	44

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	7,945,823	8,012,590	(66,767)	(0.8%)
OneCare Connect	155,370	154,177	1,193	0.8%
OneCare	16,100	16,561	(461)	(2.8%)
PACE	4,163	4,170	(7)	(0.2%)
Total	8,121,456	8,187,498	(66,042)	(0.8%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 17,943	$ 21,357	$ (3,413)	(16.0%)
OneCare Connect	(1,791)	(13,872)	12,081	87.1%
OneCare	(2,312)	(1,222)	(1,090)	(89.2%)
PACE	4,810	2,171	2,639	121.6%
505 Bldg.	-	-	-	0.0%
Investment Income	40,532	13,750	26,782	194.8%
Total	$ 59,183	$ 22,184	$ 36,999	166.8%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.1%	95.2%	(1.0)
OneCare Connect	94.5%	97.8%	3.3
OneCare	105.3%	97.8%	(7.5)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 104,227	$ 121,004	$ 16,777	13.9%
OneCare Connect	17,318	19,703	2,385	12.1%
OneCare	1,583	1,619	36	2.2%
PACE	1,873	2,011	138	6.9%
Total	$ 125,001	$ 144,338	$ 19,337	13.4%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	11,494	12,862	1,368
OneCare Connect	2,133	2,272	139
OneCare	106	102	(3)
PACE	814	1,015	201
Total	14,547	16,252	1,705

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	691	623	68
OneCare Connect	73	68	5
OneCare	152	162	(10)
PACE	5	4	1
Total	922	857	65

CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended May 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	744,831		735,957		8,874	
REVENUE						
Medi-Cal	$ 253,237,952	$ 347.32	$ 268,143,663	$ 372.32	$ (14,905,711)	$ (25.00)
OneCare Connect	25,946,014	1,865.01	23,803,729	1,722.54	2,142,285	142.47
OneCare	1,796,622	1,279.65	1,624,190	1,070.66	172,432	208.99
PACE	3,169,451	7,963.44	3,258,371	7,739.60	(88,920)	223.84
Total Operating Revenue	284,150,040	381.50	296,829,953	403.33	(12,679,914)	(21.83)
MEDICAL EXPENSES						
Medi-Cal	247,456,733	339.39	259,266,513	359.99	11,809,780	20.60
OneCare Connect	21,497,956	1,545.28	23,385,321	1,692.26	1,887,365	146.98
OneCare	1,355,895	965.74	1,610,674	1,061.75	254,779	96.01
PACE	2,424,854	6,092.60	2,819,659	6,697.53	394,805	604.93
Total Medical Expenses	272,735,437	366.17	287,082,167	390.08	14,346,730	23.91
GROSS MARGIN	11,414,602	15.33	9,747,786	13.25	1,666,816	2.08
ADMINISTRATIVE EXPENSES						
Salaries and benefits	7,716,677	10.36	7,988,395	10.85	271,718	0.49
Professional fees	210,344	0.28	628,251	0.85	417,907	0.57
Purchased services	1,008,039	1.35	1,536,360	2.09	528,321	0.74
Printing & Postage	525,194	0.71	521,297	0.71	(3,897)	-
Depreciation & Amortization	315,413	0.42	457,866	0.62	142,453	0.20
Other expenses	1,445,864	1.94	2,036,397	2.77	590,533	0.83
Indirect cost allocation & Occupancy expense	315,021	0.42	375,260	0.51	60,239	0.09
Total Administrative Expenses	11,536,552	15.49	13,543,826	18.40	2,007,274	2.91
INCOME (LOSS) FROM OPERATIONS	(121,950)	(0.16)	(3,796,040)	(5.16)	3,674,091	5.00
INVESTMENT INCOME						
Interest income	1,528,993	2.05	1,250,000	1.70	278,993	0.35
Realized gain/(loss) on investments	256,442	0.34	-	-	256,442	0.34
Unrealized gain/(loss) on investments	2,256,791	3.03	-	-	2,256,791	3.03
Total Investment Income	4,042,226	5.43	1,250,000	1.70	2,792,226	3.73
TOTAL MCO TAX	604,300	0.81	-	-	604,300	0.81
TOTAL GRANT INCOME	9,225	0.01	-	-	9,225	0.01
OTHER INCOME	642	-	-	-	642	-
CHANGE IN NET ASSETS	**4,534,443**	**6.09**	**(2,546,040)**	**(3.46)**	**7,080,483**	**9.55**
MEDICAL LOSS RATIO	**96.0%**		**96.7%**		**0.7%**	
ADMINISTRATIVE LOSS RATIO	**4.1%**		**4.6%**		**0.5%**	

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	8,121,456		8,187,498		(66,042)	
REVENUE						
Medi-Cal	$ 3,180,727,830	$ 400.30	$ 2,955,862,150	$ 368.90	$ 224,865,681	$ 31.40
OneCare Connect	283,946,427	1,827.55	262,887,315	1,705.10	21,059,112	122.45
OneCare	13,645,557	847.55	18,009,937	1,087.49	(4,364,380)	(239.94)
PACE	33,825,254	8,125.21	32,363,848	7,761.11	1,461,406	364.10
Total Operating Revenue	3,512,145,068	432.45	3,269,123,250	399.28	243,021,819	33.17
MEDICAL EXPENSES						
Medi-Cal	3,057,789,340	384.83	2,813,501,298	351.14	(244,288,043)	(33.69)
OneCare Connect	268,418,818	1,727.61	257,055,927	1,667.28	(11,362,891)	(60.33)
OneCare	14,374,921	892.85	17,612,940	1,063.52	3,238,019	170.67
PACE	27,141,751	6,519.76	28,181,275	6,758.10	1,039,524	238.34
Total Medical Expenses	3,367,724,830	414.67	3,116,351,440	380.62	(251,373,390)	(34.05)
GROSS MARGIN	144,420,238	17.78	152,771,810	18.66	(8,351,572)	(0.88)
ADMINISTRATIVE EXPENSES						
Salaries and benefits	81,858,293	10.08	89,662,439	10.95	7,804,146	0.87
Professional fees	2,930,157	0.36	5,445,982	0.67	2,515,825	0.31
Purchased services	11,143,691	1.37	14,273,954	1.74	3,130,263	0.37
Printing & Postage	4,908,151	0.60	6,092,292	0.74	1,184,141	0.14
Depreciation & Amortization	3,862,950	0.48	5,036,526	0.62	1,173,576	0.14
Other expenses	16,566,257	2.04	19,631,544	2.40	3,065,287	0.36
Indirect cost allocation & Occupancy expense	3,731,725	0.46	4,195,109	0.51	463,384	0.05
Total Administrative Expenses	125,001,224	15.39	144,337,846	17.63	19,336,622	2.24
INCOME (LOSS) FROM OPERATIONS	19,419,014	2.39	8,433,964	1.03	10,985,050	1.36
INVESTMENT INCOME						
Interest income	27,775,342	3.42	13,750,000	1.68	14,025,342	1.74
Realized gain/(loss) on investments	3,875,865	0.48	-	-	3,875,865	0.48
Unrealized gain/(loss) on investments	8,881,018	1.09	-	-	8,881,018	1.09
Total Investment Income	40,532,225	4.99	13,750,000	1.68	26,782,225	3.31
TOTAL MCO TAX	(739,918)	(0.09)	-	-	(739,918)	(0.09)
TOTAL GRANT INCOME	(29,248)	-	-	-	(29,248)	-
OTHER INCOME	1,204	-	-	-	1,204	-
CHANGE IN NET ASSETS	**59,183,275**	**7.29**	**22,183,964**	**2.71**	**36,999,311**	**4.58**
MEDICAL LOSS RATIO	**95.9%**		**95.3%**		**-0.6%**	
ADMINISTRATIVE LOSS RATIO	**3.6%**		**4.4%**		**0.9%**	

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended May 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	485,769	232,639	10,709	729,117	13,912	1,404	398	744,831
REVENUES								
Capitation Revenue	127,323,854	$ 105,930,947	$ 19,983,152	$ 253,237,952	$ 25,946,014	$ 1,796,622	$ 3,169,451	$ 284,150,040
Total Operating Revenue	127,323,854	105,930,947	19,983,152	253,237,952	25,946,014	1,796,622	3,169,451	284,150,040
MEDICAL EXPENSES								
Provider Capitation	41,125,140	46,304,978	7,513,741	94,943,859	10,379,466	539,349		105,862,674
Facilities	19,080,132	13,313,697	3,678,096	36,071,926	2,323,675	255,308	662,731	39,313,641
Professional Claims	12,869,384	6,344,624	1,074,004	20,288,013	663,079	46,867	525,465	21,523,424
Prescription Drugs	18,981,760	23,369,833	6,033,922	48,385,515	5,730,870	439,490	283,564	54,839,439
MLTSS	37,117,089	2,804,221	1,761,468	41,682,778	1,236,998	48,203	5,251	42,973,229
Medical Management	2,085,416	1,317,889	276,089	3,679,394	949,034	26,678	746,402	5,401,508
Quality Incentives	914,256	466,023	139,830	1,520,109	206,720		4,975	1,731,804
Reinsurance & Other	436,587	433,263	15,290	885,140	8,114		196,465	1,089,719
Total Medical Expenses	132,609,764	94,354,528	20,492,442	247,456,733	21,497,956	1,355,895	2,424,854	272,735,437
Medical Loss Ratio	104.2%	89.1%	102.5%	97.7%	82.9%	75.5%	76.5%	96.0%
GROSS MARGIN	**(5,285,910)**	**11,576,419**	**(509,289)**	**5,781,219**	**4,448,059**	**440,727**	**744,597**	**11,414,602**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				6,733,341	765,889	90,694	126,753	7,716,677
Professional fees				180,608	14,613	15,000	123	210,344
Purchased services				876,378	110,547	7,827	13,288	1,008,039
Printing & Postage				346,023	173,297	5,824	50	525,194
Depreciation & Amortization				313,333			2,079	315,413
Other expenses				1,404,402	37,910		3,552	1,445,864
Indirect cost allocation & Occupancy				(278,570)	552,199	37,170	4,221	315,021
Total Administrative Expenses				9,575,516	1,654,454	156,515	150,067	11,536,552
Admin Loss Ratio				3.8%	6.4%	8.7%	4.7%	4.1%
INCOME (LOSS) FROM OPERATIONS				(3,794,296)	2,793,605	284,212	594,530	(121,950)
INVESTMENT INCOME								4,042,226
TOTAL MCO TAX				604,300				604,300
TOTAL GRANT INCOME				9,225				9,225
OTHER INCOME				642				642
CHANGE IN NET ASSETS				**$ (3,180,130)**	**$ 2,793,605**	**$ 284,212**	**$ 594,530**	**$ 4,534,443**
BUDGETED CHANGE IN NET ASSETS				(2,611,059)	(1,311,471)	(132,425)	258,915	(2,546,040)
VARIANCE TO BUDGET - FAV (UNFAV)				$ (569,071)	$ 4,105,076	$ 416,637	$ 335,615	$ 7,080,483

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ended May 31, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,309,499	2,511,052	125,272	7,945,823	155,370	16,100	4,163	8,121,456
REVENUES								
Capitation Revenue	1,708,436,053	$ 1,227,636,189	$ 244,655,588	$ 3,180,727,830	$ 283,946,427	$ 13,645,557	$ 33,825,254	$ 3,512,145,068
Total Operating Revenue	1,708,436,053	1,227,636,189	244,655,588	3,180,727,830	283,946,427	13,645,557	33,825,254	3,512,145,068
MEDICAL EXPENSES								
Provider Capitation	430,459,526	485,043,452	107,347,012	1,022,849,990	125,837,091	3,259,333		1,151,946,413
Facilities	264,219,037	226,227,804	56,148,635	546,595,476	40,686,958	4,307,256	7,294,114	598,883,804
Ancillary	-	-	-	-	-	-	-	-
Professional Claims	192,597,320	77,167,373	15,804,401	285,569,095	8,260,526	553,711	6,245,969	300,629,301
Prescription Drugs	215,149,462	227,526,805	62,865,901	505,542,169	63,151,497	5,531,129	2,733,055	576,957,848
MLTSS	378,802,157	28,970,050	18,286,483	426,058,690	14,600,943	278,848	351,092	441,289,573
Medical Management	23,339,544	13,995,249	2,816,371	40,151,163	11,882,859	444,645	8,090,636	60,569,303
Quality Incentives	10,429,848	5,286,962	1,561,838	17,278,648	2,218,500		206,247	19,703,396
Reinsurance & Other	123,213,917	90,183,254	346,939	213,744,110	1,780,445		2,220,637	217,745,192
Total Medical Expenses	1,638,210,812	1,154,400,949	265,177,580	3,057,789,340	268,418,818	14,374,921	27,141,751	3,367,724,830
Medical Loss Ratio	95.9%	94.0%	108.4%	96.1%	94.5%	105.3%	80.2%	95.9%
GROSS MARGIN	**70,225,241**	**73,235,241**	**(20,521,991)**	**122,938,490**	**15,527,610**	**(729,364)**	**6,683,503**	**144,420,238**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				71,548,956	7,991,693	761,948	1,555,697	81,858,293
Professional fees				2,232,548	491,486	204,371	1,753	2,930,157
Purchased services				9,441,376	1,465,323	135,776	101,216	11,143,691
Printing & Postage				3,872,117	878,674	56,013	101,347	4,908,151
Depreciation & Amortization				3,840,030			22,919	3,862,950
Other expenses				16,162,719	358,086	2,472	42,979	16,566,257
Indirect cost allocation & Occupancy				(2,870,562)	6,132,949	422,146	47,192	3,731,725
Total Administrative Expenses				104,227,185	17,318,210	1,582,727	1,873,102	125,001,224
Admin Loss Ratio				3.3%	6.1%	11.6%	5.5%	3.6%
INCOME (LOSS) FROM OPERATIONS				18,711,305	(1,790,601)	(2,312,091)	4,810,401	19,419,014
INVESTMENT INCOME								40,532,225
TOTAL MCO TAX				(739,918)				(739,918)
TOTAL GRANT INCOME				(29,248)				(29,248)
OTHER INCOME				1,204				1,204
CHANGE IN NET ASSETS				**$ 17,943,342**	**$ (1,790,601)**	**$ (2,312,091)**	**$ 4,810,401**	**$ 59,183,275**
BUDGETED CHANGE IN NET ASSETS				21,356,621	(13,871,998)	(1,221,884)	2,171,225	22,183,964
VARIANCE TO BUDGET - FAV (UNFAV)				$ (3,413,279)	$ 12,081,397	$ (1,090,207)	$ 2,639,176	$ 36,999,311

May 31, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $4.5 million, $7.1 million favorable to budget
- Operating deficit is $0.1 million, with a surplus in non-operating income of $4.7 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $59.2 million, $37.0 million favorable to budget
- Operating surplus is $19.4 million, with a surplus in non-operating income of $39.8 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(3.8)	(2.6)	(1.2)	Medi-Cal	18.7	21.4	(2.6)
2.8	(1.3)	4.1	OCC	(1.8)	(13.9)	12.1
0.3	(0.1)	0.4	OneCare	(2.3)	(1.2)	(1.1)
0.6	0.3	0.3	PACE	4.8	2.2	2.6
(0.1)	**(3.8)**	**3.7**	**Operating**	**19.4**	**8.4**	**11.0**
4.7	1.3	3.4	Inv./Rental Inc, MCO tax	39.8	13.8	26.0
4.7	**1.3**	**3.4**	**Non-Operating**	**39.8**	**13.8**	**26.0**
4.5	**(2.5)**	**7.1**	**TOTAL**	**59.2**	**22.2**	**37.0**

CalOptima - Consolidated
Enrollment Summary
For the Eleven Months Ended May 31, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,799	66,504	295	0.4%	Aged	726,552	724,306	2,246	0.3%
506	615	(109)	(17.7%)	BCCTP	5,792	6,765	(973)	(14.4%)
44,970	43,518	1,452	3.3%	Disabled	492,916	480,608	12,308	2.6%
282,075	273,956	8,119	3.0%	TANF Child	3,099,632	3,088,065	11,567	0.4%
87,927	83,343	4,584	5.5%	TANF Adult	946,214	942,769	3,445	0.4%
3,492	3,404	88	2.6%	LTC	38,392	37,444	948	2.5%
232,639	235,920	(3,281)	(1.4%)	MCE	2,511,052	2,590,293	(79,241)	(3.1%)
10,709	12,940	(2,231)	(17.2%)	WCM	125,272	142,340	(17,068)	(12.0%)
729,117	**720,200**	**8,917**	**1.2%**	**Medi-Cal Total**	**7,945,823**	**8,012,590**	**(66,767)**	**(0.8%)**
13,912	**13,819**	**93**	**0.7%**	**OneCare Connect**	**155,370**	**154,177**	**1,193**	**0.8%**
1,404	**1,517**	**(113)**	**(7.4%)**	**OneCare**	**16,100**	**16,561**	**(461)**	**(2.8%)**
398	**421**	**(23)**	**(5.5%)**	**PACE**	**4,163**	**4,170**	**(7)**	**(0.2%)**
744,831	**735,957**	**8,874**	**1.2%**	**CalOptima Total**	**8,121,456**	**8,187,498**	**(66,042)**	**(0.8%)**
				Enrollment (by Network)				
163,717	159,915	3,802	2.4%	HMO	1,755,195	1,778,067	(22,872)	(1.3%)
208,640	204,202	4,438	2.2%	PHC	2,263,828	2,287,574	(23,746)	(1.0%)
174,152	184,223	(10,071)	(5.5%)	Shared Risk Group	1,930,165	2,052,050	(121,885)	(5.9%)
182,608	171,860	10,748	6.3%	Fee for Service	1,996,634	1,894,899	101,735	5.4%
729,117	**720,200**	**8,917**	**1.2%**	**Medi-Cal Total**	**7,945,823**	**8,012,590**	**(66,767)**	**(0.8%)**
13,912	**13,819**	**93**	**0.7%**	**OneCare Connect**	**155,370**	**154,177**	**1,193**	**0.8%**
1,404	**1,517**	**(113)**	**(7.4%)**	**OneCare**	**16,100**	**16,561**	**(461)**	**(2.8%)**
398	**421**	**(23)**	**(5.5%)**	**PACE**	**4,163**	**4,170**	**(7)**	**(0.2%)**
744,831	**735,957**	**8,874**	**1.2%**	**CalOptima Total**	**8,121,456**	**8,187,498**	**(66,042)**	**(0.8%)**

CalOptima
Enrollment Trend by Network
Fiscal Year 2020

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	YTD Actual	YTD Budget	Variance
HMOs														
Aged	3,723	3,740	3,754	3,821	3,827	3,743	3,768	3,625	3,679	3,746	3,770	41,196	41,719	(523)
BCCTP	1	1	2	2	1	1	1	1	1	1	1	13	11	2
Disabled	6,539	6,547	6,572	6,613	6,633	6,546	6,468	6,612	6,670	6,713	6,742	72,655	72,971	(316)
TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	50,877	50,743	51,816	52,360	53,207	576,874	576,872	2
TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	25,104	25,208	25,961	26,474	27,420	294,756	302,887	(8,131)
LTC	2	1	3	3	2	4		5	1	1	3	25	22	3
MCE	68,973	69,077	68,729	68,881	68,361	68,256	62,418	66,229	67,457	69,104	70,666	748,151	757,592	(9,441)
WCM	2,026	2,087	2,052	1,987	2,006	2,024	1,692	1,937	1,894	1,912	1,908	21,525	25,993	(4,468)
Total	**163,254**	**162,896**	**161,178**	**161,655**	**160,633**	**159,384**	**150,328**	**154,360**	**157,479**	**160,311**	**163,717**	**1,755,195**	**1,778,067**	**(22,872)**
PHCs														
Aged	1,548	1,540	1,524	1,542	1,577	1,579	1,516	1,448	1,474	1,493	1,539	16,780	16,695	85
BCCTP												-		0
Disabled	5,416	5,499	5,323	5,425	5,500	5,474	5,244	5,422	5,436	5,482	5,497	59,718	58,598	1,120
TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	143,833	140,195	142,951	144,407	146,437	1,590,974	1,603,379	(12,405)
TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	9,797	9,907	10,366	10,489	10,846	117,694	109,832	7,862
LTC			1		1	1	2	2	1			8		8
MCE	37,510	37,479	37,084	37,037	36,728	36,708	33,716	35,640	36,168	36,723	37,741	402,534	414,546	(12,012)
WCM	7,209	7,276	7,190	7,151	7,070	6,994	6,371	6,803	6,763	6,713	6,580	76,120	84,524	(8,404)
Total	**211,497**	**211,247**	**206,041**	**208,410**	**207,353**	**202,278**	**200,479**	**199,417**	**203,159**	**205,307**	**208,640**	**2,263,828**	**2,287,574**	**(23,746)**
Shared Risk Groups														
Aged	3,569	3,523	3,470	3,501	3,527	3,364	3,301	3,225	3,223	3,226	3,276	37,205	39,877	(2,672)
BCCTP						1	(1)	1				1		1
Disabled	7,275	7,294	7,144	7,177	7,200	7,139	6,724	7,092	7,010	6,980	7,020	78,055	74,524	3,531
TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	56,508	54,614	55,822	56,162	57,113	637,932	671,860	(33,928)
TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	24,473	24,861	25,641	26,092	27,224	294,847	311,000	(16,153)
LTC	1	3	3	2	1	1		1	1			13	11	2
MCE	84,595	83,922	82,492	81,749	80,096	79,714	69,637	73,826	74,815	76,187	78,198	865,231	933,141	(67,910)
WCM	1,732	1,706	1,620	1,598	1,581	1,593	1,367	1,457	1,470	1,436	1,321	16,881	21,637	(4,756)
Total	**189,144**	**187,219**	**179,572**	**181,034**	**178,041**	**175,852**	**162,009**	**165,077**	**167,982**	**170,083**	**174,152**	**1,930,165**	**2,052,050**	**(121,885)**
Fee for Service (Dual)														
Aged	51,730	52,454	52,097	52,050	52,649	51,770	54,711	52,919	52,855	53,118	53,097	579,450	575,998	3,452
BCCTP	15	18	17	18	19	20	13	10	12	12	18	172	198	(26)
Disabled	20,752	20,053	20,586	20,577	20,781	20,848	20,986	20,729	21,085	20,778	20,714	227,889	225,604	2,285
TANF Child		19	1	1	1	1	1	1	1	1	1	28		28
TANF Adult	964	1,923	949	941	963	938	1,528	917	847	834	883	11,687	9,567	2,120
LTC	3,044	3,097	3,061	3,161	3,204	2,971	3,389	3,142	3,157	3,192	3,138	34,556	33,539	1,017
MCE	2,116	2,171	1,935	1,717	1,737	2,255	876	1,084	1,135	1,144	1,278	17,448	22,715	(5,267)
WCM	15	15	15	16	15	16	15	14	13	13	14	161	176	(15)
Total	**78,636**	**79,750**	**78,661**	**78,481**	**79,369**	**78,819**	**81,519**	**78,816**	**79,105**	**79,092**	**79,143**	**871,391**	**867,797**	**3,594**
Fee for Service (Non-Dual - Total)														
Aged	4,682	4,211	4,370	4,583	4,890	3,841	4,864	5,163	5,011	5,189	5,117	51,921	50,017	1,904
BCCTP	550	542	484	532	525	518	506	473	489	500	487	5,606	6,556	(950)
Disabled	4,928	5,692	4,374	4,930	5,428	8,670	483	5,084	4,908	5,105	4,997	54,599	48,911	5,688
TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	32,748	29,586	27,971	27,997	25,317	293,824	235,954	57,870
TANF Adult	19,658	19,951	19,512	19,854	23,011	22,542	18,203	21,106	20,816	21,023	21,554	227,230	209,483	17,747
LTC	328	326	331	347	364	302	358	359	359	365	351	3,790	3,872	(82)
MCE	40,680	41,152	40,342	41,308	48,994	48,138	37,208	44,795	45,007	45,308	44,756	477,688	462,299	15,389
WCM	843	960	978	1,008	1,079	874	936	1,043	1,022	956	886	10,585	10,010	575
Total	**97,240**	**104,940**	**86,516**	**97,857**	**114,205**	**106,079**	**95,306**	**107,609**	**105,583**	**106,443**	**103,465**	**1,125,243**	**1,027,102**	**98,141**
Grand Totals														
Aged	65,252	65,468	65,215	65,497	66,470	64,297	68,160	66,380	66,242	66,772	66,799	726,552	724,306	2,246
BCCTP	566	561	503	552	545	540	519	485	502	513	506	5,792	6,765	(973)
Disabled	44,910	45,085	43,999	44,722	45,542	48,677	39,905	44,939	45,109	45,058	44,970	492,916	480,608	12,308
TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	283,967	275,139	278,561	280,927	282,075	3,099,632	3,088,065	11,567
TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	79,105	81,999	83,631	84,912	87,927	946,214	942,769	3,445
LTC	3,375	3,427	3,399	3,513	3,572	3,279	3,749	3,509	3,519	3,558	3,492	38,392	37,444	948
MCE	233,874	233,801	230,582	230,692	235,916	235,071	203,855	221,574	224,582	228,466	232,639	2,511,052	2,590,293	(79,241)
WCM	11,825	12,044	11,855	11,760	11,751	11,501	10,381	11,254	11,162	11,030	10,709	125,272	142,340	(17,068)
Total MediCal MM	**739,771**	**746,052**	**711,968**	**727,437**	**739,601**	**722,412**	**689,641**	**705,279**	**713,308**	**721,236**	**729,117**	**7,945,823**	**8,012,590**	**(66,767)**
OneCare Connect	**14,257**	**14,090**	**14,186**	**14,093**	**14,065**	**14,264**	**14,104**	**14,171**	**14,077**	**14,151**	**13,912**	**155,370**	**154,177**	**1,193**
OneCare	**1,530**	**1,545**	**1,564**	**1,567**	**1,498**	**1,465**	**1,417**	**1,382**	**1,364**	**1,364**	**1,404**	**16,100**	**16,561**	**(461)**
PACE	**335**	**345**	**356**	**368**	**375**	**393**	**394**	**396**	**400**	**403**	**398**	**4,163**	**4,170**	**(7)**
Grand Total	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**	**738,534**	**705,556**	**721,228**	**729,149**	**737,154**	**744,831**	**8,121,456**	**8,187,498**	**(66,042)**

ENROLLMENT:

Overall, May enrollment was 744,831

- Favorable to budget 8,874 or 1.2%
- Increased 7,677 or 1.0% from prior month (PM) (April 2020)
- Decreased 15,590 or 2.1% from prior year (PY) (May 2019)

Medi-Cal enrollment was 729,117

- Favorable to budget 8,917 or 1.2%
  - Temporary Assistance for Needy Families (TANF) favorable 12,703
  - Seniors and Persons with Disabilities (SPD) favorable 1,638
  - Long-Term Care (LTC) favorable 88
  - Medi-Cal Expansion (MCE) unfavorable 3,281
  - Whole Child Model (WCM) unfavorable 2,231
- Increased 7,881 from PM

OneCare Connect enrollment was 13,912

- Favorable to budget 93 or 0.7%
- Decreased 239 from PM

OneCare enrollment was 1,404

- Unfavorable to budget 113 or 7.4%
- Increased 40 from PM

PACE enrollment was 398

- Unfavorable to budget 23 or 5.5%
- Decreased 5 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
729,117	**720,200**	**8,917**	**1.2%**	**Member Months**	**7,945,823**	**8,012,590**	**(66,767)**	**(0.8%)**
				Revenues				
253,237,952	268,143,663	(14,905,711)	(5.6%)	Capitation Revenue	3,180,727,830	2,955,862,150	224,865,681	7.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
253,237,952	**268,143,663**	**(14,905,711)**	**(5.6%)**	**Total Operating Revenue**	**3,180,727,830**	**2,955,862,150**	**224,865,681**	**7.6%**
				Medical Expenses				
96,463,967	95,003,747	(1,460,221)	(1.5%)	Provider Capitation	1,040,128,638	1,045,984,532	5,855,894	0.6%
36,071,926	49,222,831	13,150,905	26.7%	Facilities Claims	546,595,476	531,930,564	(14,664,912)	(2.8%)
20,288,013	23,744,496	3,456,483	14.6%	Professional Claims	285,569,095	254,818,772	(30,750,323)	(12.1%)
48,385,515	44,600,895	(3,784,620)	(8.5%)	Prescription Drugs	505,542,169	483,431,235	(22,110,933)	(4.6%)
41,682,778	37,875,860	(3,806,918)	(10.1%)	MLTSS	426,058,690	408,141,767	(17,916,923)	(4.4%)
3,679,394	5,575,158	1,895,764	34.0%	Medical Management	40,151,163	53,901,420	13,750,257	25.5%
885,140	3,243,527	2,358,387	72.7%	Reinsurance & Other	213,744,110	35,293,007	(178,451,103)	(505.6%)
247,456,733	**259,266,513**	**11,809,780**	**4.6%**	**Total Medical Expenses**	**3,057,789,340**	**2,813,501,298**	**(244,288,043)**	**(8.7%)**
5,781,219	**8,877,150**	**(3,095,930)**	**(34.9%)**	**Gross Margin**	**122,938,490**	**142,360,852**	**(19,422,362)**	**(13.6%)**
				Administrative Expenses				
6,733,341	6,976,908	243,567	3.5%	Salaries, Wages & Employee Benefits	71,548,956	78,411,452	6,862,496	8.8%
180,608	528,822	348,214	65.8%	Professional Fees	2,232,548	4,352,264	2,119,716	48.7%
876,378	1,357,337	480,959	35.4%	Purchased Services	9,441,376	11,704,704	2,263,328	19.3%
346,023	398,237	52,214	13.1%	Printing and Postage	3,872,117	4,738,629	866,512	18.3%
313,333	455,750	142,417	31.2%	Depreciation & Amortization	3,840,030	5,013,250	1,173,220	23.4%
1,404,402	1,955,635	551,233	28.2%	Other Operating Expenses	16,162,719	18,743,161	2,580,442	13.8%
(278,570)	(184,480)	94,090	51.0%	Indirect Cost Allocation, Occupancy Expense	(2,870,562)	(1,959,229)	911,333	46.5%
9,575,516	**11,488,209**	**1,912,693**	**16.6%**	**Total Administrative Expenses**	**104,227,185**	**121,004,231**	**16,777,046**	**13.9%**
				Operating Tax				
11,687,633	11,107,071	580,562	5.2%	Tax Revenue	57,185,582	123,547,190	(66,361,608)	(53.7%)
11,083,333	11,107,071	23,738	0.2%	Premium Tax Expense	57,925,501	123,547,190	65,621,689	53.1%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
604,300	-	604,300	**0.0%**	**Total Net Operating Tax**	(739,918)	-	(739,918)	**0.0%**
				Grant Income				
65,424	-	65,424	0.0%	Grant Revenue	286,468	-	286,468	0.0%
52,275	-	(52,275)	0.0%	Grant expense - Service Partner	213,250	-	(213,250)	0.0%
3,924	-	(3,924)	0.0%	Grant expense - Administrative	102,466	-	(102,466)	0.0%
9,225	-	9,225	**0.0%**	**Total Grant Income**	(29,248)	-	(29,248)	**0.0%**
-	**-**	**-**	**0.0%**	**QAF and IGT - Net**	**(0)**	**-**	**0**	**0.0%**
642	**-**	**642**	**0.0%**	**Other income**	**1,204**	**-**	**1,204**	**0.0%**
(3,180,130)	**(2,611,059)**	**(569,071)**	**(21.8%)**	**Change in Net Assets**	**17,943,342**	**21,356,621**	**(3,413,279)**	**(16.0%)**
97.7%	***96.7%***	***(1.0%)***	***(1.1%)***	***Medical Loss Ratio***	***96.1%***	***95.2%***	***(1.0%)***	***(1.0%)***
3.8%	***4.3%***	***0.5%***	***11.7%***	***Admin Loss Ratio***	***3.3%***	***4.1%***	***0.8%***	***20.0%***

MEDI-CAL INCOME STATEMENT – MAY MONTH:

REVENUES of $253.2 million are unfavorable to budget $14.9 million driven by:

- Favorable volume related variance of $3.3 million
- Unfavorable price related variance of $18.2 million due to:
  - $8.6 million of Behavioral Health Treatment (BHT) revenue
  - $5.8 million of revenue from initial estimates of May Revise impact from the Department of Health Care Services (DHCS)
  - $3.3 million of WCM revenue

MEDICAL EXPENSES of $247.5 million are favorable to budget $11.8 million driven by:

- Unfavorable volume related variance of $3.2 million
- Favorable price related variance of $15.0 million due to:
  - Facilities Claims expense favorable variance of $13.8 million due to decreased utilization during COVID-19 pandemic
  - Professional Claims expense favorable variance of $3.8 million due to decreased utilization during COVID-19 pandemic
  - Reinsurance & Other expense favorable variance of $2.4 million due to decreased utilization during COVID-19 pandemic
  - Medical Management expense favorable variance of $2.0 million
  - MLTSS expense unfavorable variance of $3.3 million due to a temporary increase in reimbursement to LTC facilities implemented by DHCS
  - Prescription Drugs expense unfavorable variance of $3.2 million due to increased utilization

ADMINISTRATIVE EXPENSES of $9.6 million are favorable to budget $1.9 million driven by:

- Salaries & Benefit expense favorable to budget $0.2 million
- Other Non-Salary expense favorable to budget $1.7 million

CHANGE IN NET ASSETS is ($3.2) million for the month, unfavorable to budget $0.6 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Eleven Months Ending May 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
13,912	**13,819**	**93**	**0.7%**	**Member Months**	**155,370**	**154,177**	**1,193**	**0.8%**
				Revenues				
2,646,322	2,705,114	(58,792)	(2.2%)	Medi-Cal Capitation Revenue	27,650,719	30,348,546	(2,697,827)	(8.9%)
18,257,515	16,315,471	1,942,044	11.9%	Medicare Capitation Revenue Part C	196,888,495	179,793,784	17,094,711	9.5%
5,042,178	4,783,144	259,034	5.4%	Medicare Capitation Revenue Part D	59,407,213	52,744,985	6,662,228	12.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
25,946,014	**23,803,729**	**2,142,285**	**9.0%**	**Total Operating Revenue**	**283,946,427**	**262,887,315**	**21,059,112**	**8.0%**
				Medical Expenses				
10,586,186	10,758,948	172,762	1.6%	Provider Capitation	128,055,591	119,945,612	(8,109,979)	(6.8%)
2,323,675	3,582,867	1,259,192	35.1%	Facilities Claims	40,686,958	38,652,727	(2,034,231)	(5.3%)
663,079	714,893	51,814	7.2%	Ancillary	8,260,526	7,575,538	(684,988)	(9.0%)
1,236,998	1,527,077	290,079	19.0%	MLTSS	14,600,943	16,882,695	2,281,752	13.5%
5,730,870	5,459,571	(271,299)	(5.0%)	Prescription Drugs	63,151,497	59,222,068	(3,929,429)	(6.6%)
949,034	1,118,659	169,625	15.2%	Medical Management	11,882,859	12,363,779	480,920	3.9%
8,114	223,306	215,192	96.4%	Other Medical Expenses	1,780,445	2,413,508	633,063	26.2%
21,497,956	**23,385,321**	**1,887,365**	**8.1%**	**Total Medical Expenses**	**268,418,818**	**257,055,927**	**(11,362,891)**	**(4.4%)**
4,448,059	**418,408**	**4,029,651**	**963.1%**	**Gross Margin**	**15,527,610**	**5,831,388**	**9,696,222**	**166.3%**
				Administrative Expenses				
765,889	821,554	55,665	6.8%	Salaries, Wages & Employee Benefits	7,991,693	9,111,809	1,120,116	12.3%
14,613	77,796	63,184	81.2%	Professional Fees	491,486	855,755	364,269	42.6%
110,547	142,989	32,442	22.7%	Purchased Services	1,465,323	2,172,876	707,553	32.6%
173,297	95,860	(77,437)	(80.8%)	Printing and Postage	878,674	1,054,463	175,789	16.7%
-	-	-	0.0%	Depreciation & Amortization	-	-	-	0.0%
37,910	71,888	33,978	47.3%	Other Operating Expenses	358,086	790,771	432,685	54.7%
552,199	519,792	(32,407)	(6.2%)	Indirect Cost Allocation	6,132,949	5,717,712	(415,237)	(7.3%)
1,654,454	**1,729,879**	**75,425**	**4.4%**	**Total Administrative Expenses**	**17,318,210**	**19,703,386**	**2,385,176**	**12.1%**
				Operating Tax				
-	-	-	0.0%	Tax Revenue	-	-	-	0.0%
-	-	-	0.0%	Premium Tax Expense	-	-	-	0.0%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
2,793,605	**(1,311,471)**	**4,105,076**	**313.0%**	**Change in Net Assets**	**(1,790,601)**	**(13,871,998)**	**12,081,397**	**87.1%**
82.9%	***98.2%***	***15.4%***	***15.7%***	***Medical Loss Ratio***	***94.5%***	***97.8%***	***3.3%***	***3.3%***
6.4%	***7.3%***	***0.9%***	***12.3%***	***Admin Loss Ratio***	***6.1%***	***7.5%***	***1.4%***	***18.6%***

ONECARE CONNECT INCOME STATEMENT– MAY MONTH:

REVENUES of $25.9 million are favorable to budget $2.1 million driven by:

- Favorable volume related variance of $0.2 million
- Favorable price related variance of $2.0 million due to:
  - $1.4 million of revenue from calendar year (CY) 2020 mid-year Hierarchical Condition Category (HCC) reconciliation

MEDICAL EXPENSES of $21.5 million are favorable to budget $1.9 million driven by:

- Unfavorable volume related variance of $0.2 million
- Favorable price related variance of $2.0 million due to:
  - Facilities Claims expense favorable variance of $1.3 million due to decreased utilization during COVID-19 pandemic
  - MLTSS expense favorable variance of $0.3 million
  - Provider Capitation expense favorable variance of $0.2 million

ADMINISTRATIVE EXPENSES of $1.7 million are favorable to budget $0.1 million

CHANGE IN NET ASSETS is $2.8 million, favorable to budget $4.1 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,404	**1,517**	**(113)**	**(7.4%)**	**Member Months**	**16,100**	**16,561**	**(461)**	**(2.8%)**
				Revenues				
1,390,729	1,101,106	289,623	26.3%	Medicare Part C revenue	8,025,086	12,282,764	(4,257,678)	(34.7%)
405,893	523,084	(117,191)	(22.4%)	Medicare Part D revenue	5,620,471	5,727,173	(106,702)	(1.9%)
1,796,622	**1,624,190**	**172,432**	**10.6%**	**Total Operating Revenue**	**13,645,557**	**18,009,937**	**(4,364,380)**	**(24.2%)**
				Medical Expenses				
539,349	426,501	(112,848)	(26.5%)	Provider Capitation	3,259,333	4,817,043	1,557,710	32.3%
255,308	516,948	261,640	50.6%	Inpatient	4,307,256	5,559,438	1,252,182	22.5%
46,867	56,442	9,575	17.0%	Ancillary	553,711	607,283	53,572	8.8%
48,203	46,376	(1,827)	(3.9%)	Skilled Nursing Facilities	278,848	498,854	220,006	44.1%
439,490	506,250	66,760	13.2%	Prescription Drugs	5,531,129	5,483,374	(47,755)	(0.9%)
26,678	47,208	20,530	43.5%	Medical Management	444,645	527,420	82,775	15.7%
-	10,949	10,949	100.0%	Other Medical Expenses	-	119,528	119,528	100.0%
1,355,895	**1,610,674**	**254,779**	**15.8%**	**Total Medical Expenses**	**14,374,921**	**17,612,940**	**3,238,019**	**18.4%**
440,727	**13,516**	**427,211**	**3160.8%**	**Gross Margin**	**(729,364)**	**396,997**	**(1,126,361)**	**(283.7%)**
				Administrative Expenses				
90,694	50,404	(40,290)	(79.9%)	Salaries, wages & employee benefits	761,948	567,974	(193,974)	(34.2%)
15,000	21,480	6,480	30.2%	Professional fees	204,371	236,280	31,909	13.5%
7,827	17,063	9,236	54.1%	Purchased services	135,776	187,693	51,917	27.7%
5,824	16,667	10,843	65.1%	Printing and postage	56,013	183,337	127,324	69.4%
-	4,738	4,738	100.0%	Other operating expenses	2,472	52,118	49,646	95.3%
37,170	35,589	(1,581)	(4.4%)	Indirect cost allocation, occupancy expens	422,146	391,479	(30,667)	(7.8%)
156,515	**145,941**	**(10,574)**	**(7.2%)**	**Total Administrative Expenses**	**1,582,727**	**1,618,881**	**36,154**	**2.2%**
284,212	**(132,425)**	**416,637**	**314.6%**	**Change in Net Assets**	**(2,312,091)**	**(1,221,884)**	**(1,090,207)**	**(89.2%)**
75.5%	***99.2%***	***23.7%***	***23.9%***	***Medical Loss Ratio***	***105.3%***	***97.8%***	***(7.5%)***	***(7.7%)***
8.7%	***9.0%***	***0.3%***	***3.0%***	***Admin Loss Ratio***	***11.6%***	***9.0%***	***(2.6%)***	***(29.0%)***

CalOptima
PACE
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
398	**421**	**(23)**	**(5.5%)**	**Member Months**	**4,163**	**4,170**	**(7)**	**-0.2%**
				Revenues				
2,387,028	2,532,716	(145,688)	(5.8%)	Medi-Cal Capitation Revenue	26,385,531	25,071,019	1,314,512	5.2%
629,049	570,671	58,378	10.2%	Medicare Part C Revenue	5,743,324	5,754,521	(11,197)	(0.2%)
153,373	154,984	(1,611)	(1.0%)	Medicare Part D Revenue	1,696,399	1,538,308	158,091	10.3%
3,169,451	**3,258,371**	**(88,920)**	**(2.7%)**	**Total Operating Revenue**	**33,825,254**	**32,363,848**	**1,461,406**	**4.5%**
				Medical Expenses				
746,402	883,210	136,808	15.5%	Medical Management	8,090,636	9,679,538	1,588,902	16.4%
662,731	643,818	(18,913)	(2.9%)	Facilities Claims	7,294,114	6,139,657	(1,154,457)	(18.8%)
525,465	689,839	164,374	23.8%	Professional Claims	6,245,969	6,696,378	450,409	6.7%
196,465	288,731	92,266	32.0%	Patient Transportation	2,220,637	2,713,159	492,522	18.2%
283,564	263,568	(19,996)	(7.6%)	Prescription Drugs	2,733,055	2,550,415	(182,640)	(7.2%)
5,251	43,826	38,575	88.0%	MLTSS	351,092	328,794	(22,298)	(6.8%)
4,975	6,667	1,692	25.4%	Other Expenses	206,247	73,334	(132,913)	(181.2%)
2,424,854	**2,819,659**	**394,805**	**14.0%**	**Total Medical Expenses**	**27,141,751**	**28,181,275**	**1,039,524**	**3.7%**
744,597	**438,712**	**305,885**	**69.7%**	**Gross Margin**	**6,683,503**	**4,182,573**	**2,500,930**	**59.8%**
				Administrative Expenses				
126,753	139,529	12,776	9.2%	Salaries, wages & employee benefits	1,555,697	1,571,204	15,507	1.0%
123	153	30	19.3%	Professional fees	1,753	1,683	(70)	(4.1%)
13,288	18,971	5,683	30.0%	Purchased services	101,216	208,681	107,465	51.5%
50	10,533	10,483	99.5%	Printing and postage	101,347	115,863	14,516	12.5%
2,079	2,116	37	1.7%	Depreciation & amortization	22,919	23,276	357	1.5%
3,552	4,136	584	14.1%	Other operating expenses	42,979	45,494	2,515	5.5%
4,221	4,359	138	3.2%	Indirect Cost Allocation, Occupancy Expense	47,192	45,147	(2,045)	(4.5%)
150,067	**179,797**	**29,730**	**16.5%**	**Total Administrative Expenses**	**1,873,102**	**2,011,348**	**138,246**	**6.9%**
				Operating Tax				
5,906	-	5,906	0.0%	Tax Revenue	29,546	-	29,546	0.0%
5,906	-			Tax Revenue	29,546	-		
5,906	-	(5,906)	0.0%	Premium Tax Expense	29,546	-	(29,546)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
594,530	**258,915**	**335,615**	**129.6%**	**Change in Net Assets**	**4,810,401**	**2,171,225**	**2,639,176**	**121.6%**
76.5%	***86.5%***	***10.0%***	***11.6%***	***Medical Loss Ratio***	***80.2%***	***87.1%***	***6.8%***	***7.8%***
4.7%	***5.5%***	***0.8%***	***14.2%***	***Admin Loss Ratio***	***5.5%***	***6.2%***	***0.7%***	***10.9%***

CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Eleven Months Ending May 31, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
44,604	23,101	(21,503)	(93.1%)	Purchase services	525,166	254,112	(271,054)	(106.7%)
170,892	174,725	3,833	2.2%	Depreciation & amortization	1,847,819	1,921,975	74,156	3.9%
18,423	15,866	(2,557)	(16.1%)	Insurance expense	194,134	174,526	(19,608)	(11.2%)
82,754	140,162	57,408	41.0%	Repair and maintenance	1,079,375	1,541,782	462,407	30.0%
29,335	46,432	17,097	36.8%	Other Operating Expense	439,138	510,752	71,614	14.0%
(346,007)	(400,286)	(54,279)	(13.6%)	Indirect allocation, Occupancy	(4,085,631)	(4,403,147)	(317,516)	(7.2%)
-	**-**	**-**	**0.0%**	**Total Administrative Expenses**	**0**	**-**	**(0)**	**0.0%**
-	**-**	**-**	**0.0%**	**Change in Net Assets**	**(0)**	**-**	**(0)**	**0.0%**

OTHER INCOME STATEMENTS – MAY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.3 million, favorable to budget $0.4 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.6 million, favorable to budget $0.3 million

CalOptima
Balance Sheet
May 31, 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$428,367,826	Accounts Payable	$63,793,092
Investments	586,321,744	Medical Claims liability	787,943,508
Capitation receivable	412,452,692	Accrued Payroll Liabilities	12,814,321
Receivables - Other	38,549,431	Deferred Revenue	116,363,733
Prepaid expenses	7,281,766	Deferred Lease Obligations	163,581
		Capitation and Withholds	139,875,131
Total Current Assets	**1,472,973,459**	**Total Current Liabilities**	**1,120,953,366**
Capital Assets			
Furniture & Equipment	39,639,800		
Building/Leasehold Improvements	8,530,915		
505 City Parkway West	51,616,611		
	99,787,325		
Less: accumulated depreciation	(52,746,333)		
Capital assets, net	47,040,993	Other (than pensions) post	
		employment benefits liability	26,050,269
Other Assets		Net Pension Liabilities	23,610,599
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	58,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,170,614,235**
Cash and Cash Equivalents	4,488,574		
Long-term Investments	578,654,827	Deferred Inflows	
Total Board-designated Assets	583,143,401	Excess Earnings	156,330
		Change in Assumptions	4,747,505
Total Other Assets	641,642,314	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,161,656,766**	TNE	100,383,991
		Funds in Excess of TNE	894,342,154
Deferred Outflows		**TOTAL NET POSITION**	994,726,145
Contributions	686,962		
Difference in Experience	3,419,328		
Excess Earning	-		
Changes in Assumptions	6,428,159		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,172,747,215**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,172,747,215**

CalOptima
Board Designated Reserve and TNE Analysis
as of May 31, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	159,582,879				
	Tier 1 - MetLife	158,406,054				
	Tier 1 - Wells Capital	158,967,813				
Board-designated Reserve		476,956,747	313,957,380	491,532,253	162,999,367	(14,575,506)
TNE Requirement	Tier 2 - MetLife	106,186,654	100,383,991	100,383,991	5,802,663	5,802,663
	Consolidated:	**583,143,401**	**414,341,371**	**591,916,244**	**168,802,030**	**(8,772,843)**
	Current reserve level	*1.97*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
May 31, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	4,534,443	59,183,275
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	486,305	5,710,769
Changes in assets and liabilities:		
Prepaid expenses and other	620,711	(1,494,024)
Catastrophic reserves		
Capitation receivable	4,646,845	(99,060,357)
Medical claims liability	14,992,575	35,632,557
Deferred revenue	4,198,718	65,328,969
Payable to health networks	1,884,451	30,971,991
Accounts payable	11,526,823	21,126,366
Accrued payroll	(2,479,782)	3,160,652
Other accrued liabilities	(7,129)	119,069
Net cash provided by/(used in) operating activities	40,403,960	120,679,268
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	13,463,526	(12,615,447)
Change in Property and Equipment	(350,473)	(6,126,872)
Change in Board designated reserves	(2,444,175)	(22,997,993)
Change in Homeless Health Reserve	-	1,801,087
Net cash provided by/(used in) investing activities	10,668,878	(39,939,226)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	51,072,839	80,740,042
CASH AND CASH EQUIVALENTS, beginning of period	$377,294,987	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**428,367,826**	**428,367,826**

BALANCE SHEET – MAY MONTH:

ASSETS of $2.2 billion increased $34.7 million from April or 1.6%

- Operating Cash increased $51.1 million due to month end cut-off and the timing of claim payments
- Investments decreased $13.5 million due to cash flow requirements at month end
- Capitation Receivables decreased $5.7 million due to timing of capitation received

LIABILITIES of $1.2 billion increased $30.1 million from April or 2.6%

- Claims Liabilities increased $15.0 million due to increase in liability due back to DHCS
- Accounts Payable increased $11.5 million due to the payment timing of sales tax
- Deferred Revenue increased $4.2 million due to increase in revenue recognized for Proposition 56

NET ASSETS total $994.7 million

Homeless Health Initiative and Allocated Funds
as of May 31, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,500,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC - Expansion	570,000	
Funds Allocation Total		41,801,087
Program Commitment Balance, available for new initiatives:		$58,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories. This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes for May 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Human Resources Corporate Application)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
December	Medi-Cal	IS Infrastructure - Maintenance HW/SW - Microsoft True-Up	IS Infrastructure - Maintenance HW/SW - Network Connectivity - Extreme Networks	$53,000	Repurpose $53,000 from Microsoft True-Up to Network Connectivity - Extreme Networks.	2020
December	Medi-Cal	Facilities - 6th Floor Lunchroom Remodel	Facilities - Replace Conference Room AV Equipment	$13,000	To reallocate $13,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	2020
December	Medi-Cal	Facilities - Conference Room 910 Upgrades	Facilities - Replace Conference Room AV Equipment	$17,000	To reallocate $17,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	2020
January	Medi-Cal	Member Survey - CG CAHPS	Inovalon Contract for HEDIS Software Training and Support hours	$40,000	To reallocate funds from Member Survey - CG CAHPS to Inovalon Contract for HEDIS Software Training and Support hours.	2020
May	PACE	PACE Administrative - HW/SW Maint.., Travel & Training, Membership, Food Svs/Supplies	PACE Center Support - Repair & Maint..	$27,500	To reallocate budget from PACE Administrative accounts to PACE Center Support to cover maintenance charges	2020

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.

Financial Summary

Unaudited
June 2020

Board of Directors Meeting
August 6, 2020

Nancy Huang
Chief Financial Officer

Back to Agenda

FY 2019-20: Consolidated Enrollment

June 2020 MTD

Overall enrollment was 758,970 members

- Actual higher than budget 24,648 or 3.4%
  - Medi-Cal favorable to budget 24,177 or 3.4% primarily due to COVID-19
    - Temporary Assistance for Needy Families (TANF) favorable variance of 22,016
    - Medi-Cal Expansion (MCE) favorable variance of 3,302
    - Seniors and Persons with Disabilities (SPD) favorable variance of 1,954
    - Long-Term Care (LTC) favorable variance of 114
    - Whole Child Model (WCM) unfavorable variance of 3,209
  - OneCare Connect favorable to budget 578 or 4.2%
  - OneCare unfavorable to budget 68 or 4.5%
  - PACE unfavorable to budget 39 or 9.1%
- 14,139 increase or 1.9% from May
    - Medi-Cal increase of 13,652
    - OneCare Connect increase of 446
    - OneCare increase of 48
    - PACE decrease of 7

FY 2019-20: Consolidated Enrollment (cont.)

June 2020 YTD

Overall enrollment was 8,880,426 member months

- Actual lower than budget 41,394 or 0.5%
  - Medi-Cal unfavorable to budget 42,590 or 0.5%
    - MCE unfavorable variance of 75,939
    - WCM unfavorable variance of 20,277
    - TANF favorable variance 37,028
    - SPD favorable variance of 15,535
    - LTC favorable variance of 1,062
  - OneCare Connect favorable to budget 1,771 or 1.1%
  - OneCare unfavorable to budget 529 or 2.9%
  - PACE unfavorable to budget 46 or 1.0%

FY 2019-20: Consolidated Revenues

June 2020 MTD

- Actual higher than budget $32.1 million 10.8%
  - ➢ Medi-Cal favorable to budget $21.0 million or 7.9%
    - o Favorable volume variance of $9.0 million
    - o Favorable price variance of $12.0 million
      - $48.8 million of Proposition 56 revenue due to program expansion
      - $44.0 million of Intergovernmental Transfers (IGT) 9 revenue
      - $3.0 million of LTC revenue from non-LTC categories of aid
      - Offset by unfavorable $67.0 million of revenue due to Governor's budget changes, including
        - Gross Medical Expenditures (GME) risk corridor reserve
        - 1.5% reduction to fiscal year (FY) 2020 capitation rates for certain aid code categories
      - Unfavorable $14.8 million of Coordinated Care Initiative (CCI) revenue due to risk corridor and re-evaluation of prior year (PY) reserves
      - Unfavorable $2.6 million of WCM revenue

FY 2019-20: Consolidated Revenues (cont.)

June 2020 MTD (cont.)

- OneCare Connect favorable to budget $10.0 million or 42.4%
  - Favorable volume variance of $1.0 million
  - Favorable price variance of $9.0 million due to Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2020 mid-year Hierarchical Condition Category (HCC) reconciliation
- OneCare favorable to budget $0.7 million or 43.2%
  - Unfavorable volume variance of $0.1 million
  - Favorable price variance of $0.8 million
- PACE favorable to budget $0.3 million or 8.6%
  - Unfavorable volume variance of $0.3 million
  - Favorable price variance of $0.6 million

FY 2019-20: Consolidated Revenues (cont.)

June 2020 YTD

- Actual higher than budget $275.1 million or 7.7%
  - ➢ Medi-Cal favorable to budget $245.9 million or 7.6%
    - o Unfavorable volume variance of $15.7 million
    - o Favorable price variance of $261.6 million
      - $195.3 million of Directed Payments (DP) revenue
      - $60.1 million of Proposition 56 revenue due to program expansion
      - $44.0 million of IGT 9 revenue
      - $39.9 million of net CCI revenue due to updated rate offset by risk corridor
      - $29.4 million of LTC revenue from non-LTC categories of aid
      - Offset by unfavorable $67.0 million of revenue due to Governor's budget changes, including
        - GME risk corridor reserve
        - 1.5% reduction to FY 2020 capitation rates for certain aid code categories
      - Unfavorable $40.0 million of WCM revenue

FY 2019-20: Consolidated Revenues (cont.)

June 2020 YTD (cont.)

- OneCare Connect favorable to budget $31.1 million or 10.8%
  - Favorable volume variance of $3.0 million
  - Favorable price variance of $28.1 million
    - $12.7 million from CY 2019 and 2020 CMS HCC reconciliation
    - $3.7 million of CY 2015 through 2018 estimated CMS HCC records adjustment
    - $8.5 million of Part D revenue
- OneCare unfavorable to budget $3.7 million or 18.7%
  - Unfavorable volume variance of $0.6 million
  - Unfavorable price variance of $3.1 million
- PACE favorable to budget $1.7 million or 4.9%
  - Unfavorable volume variance of $0.4 million
  - Favorable price variance of $2.1 million

FY 2019-20: Consolidated Medical Expenses

June 2020 MTD

- Actual lower than budget $6.3 million or 2.2%
  - ➢ Medi-Cal favorable variance of $10.1 million or 3.9%
    - o Unfavorable volume variance of $8.6 million
    - o Favorable price variance of $18.7 million primarily due to decreased utilization during COVID-19 pandemic
      - Facilities Claims expense favorable variance of $13.5 million
      - MLTSS expense favorable variance of $11.7 million
      - Provider Capitation expense favorable variance of $5.2 million
      - Reinsurance & Other expense favorable variance of $2.2 million
      - Professional Claims expense unfavorable variance of $10.3 million due to Proposition 56
      - Prescription Drugs expense unfavorable variance of $3.5 million
  - ➢ OneCare Connect unfavorable variance of $4.2 million or 18.4%
    - o Unfavorable volume variance of $1.0 million
    - o Unfavorable price variance of $3.3 million

FY 2019-20: Consolidated Medical Expenses (cont.)

June 2020 MTD (cont.)

- OneCare favorable variance of $102.5 thousand or 6.5%
  - Favorable volume variance of $70.3 thousand
  - Favorable price variance of $32.2 thousand
- PACE favorable variance of $0.3 million or 12.0%
  - Favorable volume variance of $0.2 million
  - Favorable price variance of $0.1 million

FY 2019-20: Consolidated Medical Expenses (cont.)

June 2020 YTD

- Actual higher than budget $245.1 million or 7.2%
  - ➢ Medi-Cal unfavorable variance of $234.2 million or 7.6%
    - o Favorable volume variance of $15.0 million
    - o Unfavorable price variance of $249.2 million
      - Reinsurance and Other expense unfavorable variance of $176.6 million due to $195.5 million of DP, offset by favorable variance in Homeless Health Initiative
      - Professional Claims expense unfavorable variance of $43.2 million due to Proposition 56 and crossover claims
      - Prescription Drugs expense unfavorable variance of $29.6 million
      - MLTSS expense unfavorable variance of $9.6 million
      - Facilities Claims expense unfavorable variance of $5.6 million
      - Offset by Medical Management expense favorable variance of $13.2 million

FY 2019-20: Consolidated Medical Expenses (cont.)

June 2020 YTD (cont.)

- OneCare Connect unfavorable variance of $15.6 million or 5.6%
  - Unfavorable volume variance of $3.0 million
  - Unfavorable price variance of $12.7 million
- OneCare favorable variance of $3.3 million or 17.4%
  - Favorable volume variance of $0.6 million
  - Favorable price variance of $2.8 million
- PACE favorable variance of $1.4 million or 4.4%
  - Favorable volume variance of $0.3 million
  - Favorable price variance of $1.1 million

Medical Loss Ratio (MLR)

- June 2020 MTD: Actual: 84.2% Budget: 95.4%
- June 2020 YTD: Actual: 94.9% Budget: 95.3%

FY 2019-20: Consolidated Administrative Expenses

June 2020 MTD

- Actual higher than budget $4.1 million or 28.8%
  - Salaries, wages and benefits: unfavorable variance of $3.5 million
  - Other categories: unfavorable variance of $0.6 million

June 2020 YTD

- Actual lower than budget $15.2 million or 9.6%
  - Salaries, wages and benefits: favorable variance of $4.3 million
  - Other categories: favorable variance of $10.9 million

Administrative Loss Ratio (ALR)

- June 2020 MTD: Actual: 5.6% Budget: 4.8%
- June 2020 YTD: Actual: 3.7% Budget: 4.4%
  - Actual ALR (excluding DP revenue) is 3.9% YTD

FY 2019-20: Change in Net Assets

June 2020 MTD

- $29.3 million change in net assets
- $28.5 million favorable to budget
  - Higher than budgeted revenue of $32.1 million
  - Lower than budgeted medical expenses of $6.3 million
  - Higher than budgeted administrative expenses of $4.1 million
  - Lower than budgeted investment and other income of $5.7 million

June 2020 YTD

- $88.5 million change in net assets
- $65.5 million favorable to budget
  - Higher than budgeted revenue of $275.1 million
  - Higher than budgeted medical expenses of $245.1 million
  - Lower than budgeted administrative expenses of $15.2 million
  - Higher than budgeted investment and other income of $20.3 million

Enrollment Summary: June 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,968	66,635	333	0.5%	Aged	793,520	790,941	2,579	0.3%
504	615	(111)	(18.0%)	BCCTP	6,296	7,380	(1,084)	(14.7%)
45,215	43,483	1,732	4.0%	Disabled	538,131	524,091	14,040	2.7%
286,183	272,626	13,557	5.0%	TANF Child	3,385,815	3,360,691	25,124	0.7%
91,340	82,881	8,459	10.2%	TANF Adult	1,037,554	1,025,650	11,904	1.2%
3,518	3,404	114	3.3%	LTC	41,910	40,848	1,062	2.6%
239,310	236,008	3,302	1.4%	MCE	2,750,362	2,826,301	(75,939)	(2.7%)
9,731	12,940	(3,209)	(24.8%)	WCM	135,003	155,280	(20,277)	(13.1%)
742,769	**718,592**	**24,177**	**3.4%**	**Medi-Cal Total**	**8,688,592**	**8,731,182**	**(42,590)**	**(0.5%)**
14,358	**13,780**	**578**	**4.2%**	**OneCare Connect**	**169,728**	**167,957**	**1,771**	**1.1%**
1,452	**1,520**	**(68)**	**(4.5%)**	**OneCare**	**17,552**	**18,081**	**(529)**	**(2.9%)**
391	**430**	**(39)**	**(9.1%)**	**PACE**	**4,554**	**4,600**	**(46)**	**(1.0%)**
758,970	**734,322**	**24,648**	**3.4%**	**CalOptima Total**	**8,880,426**	**8,921,820**	**(41,394)**	**(0.5%)**

Financial Highlights: June 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
758,970	734,322	24,648	3.4%	Member Months	8,880,426	8,921,820	(41,394)	(0.5%)
328,701,248	296,642,702	32,058,546	10.8%	Revenues	3,840,846,316	3,565,765,952	275,080,365	7.7%
276,693,600	282,982,573	6,288,973	2.2%	Medical Expenses	3,644,418,430	3,399,334,013	(245,084,417)	(7.2%)
18,267,508	14,180,510	(4,086,998)	(28.8%)	Administrative Expenses	143,268,732	158,518,356	15,249,624	9.6%
33,740,140	**(520,381)**	**34,260,521**	**6583.7%**	**Operating Margin**	**53,159,154**	**7,913,583**	**45,245,571**	**571.7%**
(4,461,847)	1,250,000	(5,711,847)	(456.9%)	Non Operating Income (Loss)	35,302,415	15,000,000	20,302,415	135.3%
29,278,294	**729,619**	**28,548,674**	**3912.8%**	**Change in Net Assets**	**88,461,569**	**22,913,583**	**65,547,986**	**286.1%**
84.2%	95.4%	11.2%		Medical Loss Ratio	94.9%	95.3%	0.4%	
5.6%	4.8%	(0.8%)		Administrative Loss Ratio	3.7%	4.4%	0.7%	
10.3%	(0.2%)	10.4%		Operating Margin Ratio	1.4%	0.2%	1.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)	3.9%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Consolidated Performance Actual vs. Budget: June 2020 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
28.5	0.4	28.1	Medi-Cal	47.2	21.8	25.4
3.7	(1.1)	4.9	OCC	1.9	(15.0)	16.9
0.7	(0.1)	0.9	OneCare	(1.6)	(1.3)	(0.2)
0.8	0.3	0.5	PACE	5.6	2.5	3.1
33.7	**(0.5)**	**34.3**	**Operating**	**53.2**	**7.9**	**45.2**
(4.5)	1.3	(5.7)	Inv./Rental Inc, MCO tax	35.3	15.0	20.3
(4.5)	**1.3**	**(5.7)**	**Non-Operating**	**35.3**	**15.0**	**20.3**
29.3	**0.7**	**28.5**	**TOTAL**	**88.5**	**22.9**	**65.5**

Consolidated Revenue & Expense: June 2020 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	493,728	239,310	9,731	742,769	14,358	1,452	391	758,970
REVENUES								
Capitation Revenue	141,907,797	$ 125,406,472	$ 21,774,250	$ 289,088,519	$ 33,695,176	$ 2,304,646	$ 3,612,906	$ 328,701,248
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	141,907,797	125,406,472	21,774,250	289,088,519	33,695,176	2,304,646	3,612,906	328,701,248
MEDICAL EXPENSES								
Provider Capitation	59,640,544	54,862,921	(16,652,394)	97,851,071	15,934,115	676,242		114,461,429
Facilities	12,788,902	14,067,950	9,419,570	36,276,421	5,099,641	224,382	633,145	42,233,589
Professional Claims	21,193,493	11,634,436	1,323,720	34,151,649	988,320	51,043	654,586	35,845,598
Prescription Drugs	19,799,784	23,827,001	4,739,268	48,366,054	4,762,832	528,041	274,978	53,931,904
MLTSS	23,254,743	1,685,770	1,303,298	26,243,811	687,032	(802)	13,157	26,943,198
Medical Management	2,653,928	1,299,437	2,286,711	6,240,076	900,082	(10,066)	887,982	8,018,073
Quality Incentives	(3,118,416)	(1,782,129)	21,241	(4,879,304)	(1,166,429)		4,888	(6,040,845)
Reinsurance & Other	517,033	646,131	22,748	1,185,912	76,979		37,763	1,300,655
Total Medical Expenses	136,730,011	106,241,517	2,464,162	245,435,691	27,282,573	1,468,839	2,506,498	276,693,600
Medical Loss Ratio	96.4%	84.7%	11.3%	84.9%	81.0%	63.7%	69.4%	84.2%
GROSS MARGIN	**5,177,785**	**19,164,955**	**19,310,088**	**43,652,829**	**6,412,604**	**835,807**	**1,106,409**	**52,007,648**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				11,096,456	779,910	79,577	150,690	12,106,633
Professional fees				732,094	4,000	15,000	123	751,217
Purchased services				881,436	225,160	9,614	115,774	1,231,984
Printing & Postage				790,157	185,564	28,182	21,360	1,025,263
Depreciation & Amortization				324,423			2,084	326,507
Other expenses				2,378,790	73,466	0	33,679	2,485,936
Indirect cost allocation & Occupancy				(1,047,673)	1,423,110	(42,723)	7,255	339,969
Total Administrative Expenses				15,155,683	2,691,211	89,650	330,965	18,267,508
Admin Loss Ratio				5.2%	8.0%	3.9%	9.2%	5.6%
INCOME (LOSS) FROM OPERATIONS				28,497,146	3,721,393	746,157	775,444	33,740,140
INVESTMENT INCOME								2,495,206
TOTAL MCO TAX				(6,961,216)				(6,961,216)
TOTAL GRANT INCOME				4,163				4,163
CHANGE IN NET ASSETS				**$ 21,540,093**	**$ 3,721,393**	**$ 746,157**	**$ 775,444**	**$ 29,278,294**
BUDGETED CHANGE IN NET ASSETS				446,374	(1,146,835)	(110,516)	290,596	729,619
VARIANCE TO BUDGET - FAV (UNFAV)				$ 21,093,719	$ 4,868,228	$ 856,673	$ 484,848	$ 28,548,674

Consolidated Revenue & Expense: June 2020 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,803,227	2,750,362	135,003	8,688,592	169,728	17,552	4,554	8,880,426
REVENUES								
Capitation Revenue	1,850,343,850	$ 1,353,042,662	$ 266,429,838	$ 3,469,816,350	$ 317,641,603	$ 15,950,203	$ 37,438,160	$ 3,840,846,316
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,850,343,850	1,353,042,662	266,429,838	3,469,816,350	317,641,603	15,950,203	37,438,160	3,840,846,316
MEDICAL EXPENSES								
Provider Capitation	490,100,071	539,906,373	90,694,618	1,120,701,061	141,771,206	3,935,575		1,266,407,842
Facilities	277,007,939	240,295,754	65,568,204	582,871,897	45,786,599	4,531,638	7,927,259	641,117,393
Professional Claims	213,790,814	88,801,810	17,128,121	319,720,744	9,248,846	604,754	6,900,555	336,474,899
Prescription Drugs	234,949,247	251,353,806	67,605,169	553,908,222	67,914,328	6,059,170	3,008,033	630,889,753
MLTSS	402,056,900	30,655,819	19,589,781	452,302,501	15,287,975	278,046	364,249	468,232,771
Medical Management	25,993,472	15,294,686	5,103,081	46,391,239	12,782,941	434,579	8,978,618	68,587,376
Quality Incentives	7,311,432	3,504,834	1,583,079	12,399,345	1,052,071		211,135	13,662,551
Reinsurance & Other	123,730,950	90,829,385	369,687	214,930,022	1,857,424		2,258,400	219,045,846
Total Medical Expenses	1,774,940,823	1,260,642,466	267,641,741	3,303,225,031	295,701,390	15,843,761	29,648,249	3,644,418,430
Medical Loss Ratio	95.9%	93.2%	100.5%	95.2%	93.1%	99.3%	79.2%	94.9%
GROSS MARGIN	**75,403,026**	**92,400,196**	**(1,211,903)**	**166,591,319**	**21,940,213**	**106,443**	**7,789,911**	**196,427,886**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				82,645,413	8,771,602	841,525	1,706,386	93,964,926
Professional fees				2,964,642	495,486	219,371	1,876	3,681,374
Purchased services				10,322,812	1,690,483	145,390	216,989	12,375,674
Printing & Postage				4,662,274	1,064,238	84,194	122,707	5,933,413
Depreciation & Amortization				4,164,453			25,004	4,189,457
Other expenses				18,541,509	431,553	2,473	76,659	19,052,193
Indirect cost allocation & Occupancy				(3,918,235)	7,556,059	379,423	54,446	4,071,694
Total Administrative Expenses				119,382,868	20,009,421	1,672,376	2,204,067	143,268,732
Admin Loss Ratio				3.4%	6.3%	10.5%	5.9%	3.7%
INCOME (LOSS) FROM OPERATIONS				47,208,451	1,930,792	(1,565,934)	5,585,845	53,159,154
INVESTMENT INCOME								43,027,431
TOTAL MCO TAX				(7,701,134)				(7,701,134)
TOTAL GRANT INCOME				(25,086)				(25,086)
OTHER INCOME				1,204				1,204
CHANGE IN NET ASSETS				**$ 39,483,435**	**$ 1,930,792**	**$ (1,565,934)**	**$ 5,585,845**	**$ 88,461,569**
BUDGETED CHANGE IN NET ASSETS				21,802,995	(15,018,833)	(1,332,400)	2,461,821	22,913,583
VARIANCE TO BUDGET - FAV (UNFAV)				$ 17,680,440	$ 16,949,625	$ (233,534)	$ 3,124,024	$ 65,547,986

Balance Sheet:
As of June 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$513,517,584	Accounts Payable	$74,656,446
Investments	589,466,103	Medical Claims liability	917,152,020
Capitation receivable	403,300,444	Accrued Payroll Liabilities	13,621,878
Receivables - Other	43,069,581	Deferred Revenue	23,423,696
Prepaid expenses	6,699,209	Deferred Lease Obligations	160,858
		Capitation and Withholds	142,981,028
Total Current Assets	**1,556,052,921**	**Total Current Liabilities**	**1,171,995,925**
Capital Assets			
Furniture & Equipment	39,890,502		
Building/Leasehold Improvements	8,437,734		
505 City Parkway West	51,620,226		
	99,948,461		
Less: accumulated depreciation	(53,293,891)		
Capital assets, net	46,654,570	Other (than pensions) post employment benefits liability	26,172,858
Other Assets		Net Pension Liabilities	27,122,873
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,225,291,657**
Cash and Cash Equivalents	4,727,620		
Long-term Investments	580,156,273	Deferred Inflows	
Total Board-designated Assets	584,883,893	Excess Earnings	506,547
		Change in Assumptions	3,728,725
Total Other Assets	642,382,806	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,245,090,297**	TNE	100,573,921
		Funds in Excess of TNE	923,430,517
Deferred Outflows		**TOTAL NET POSITION**	1,024,004,439
Contributions	1,047,297		
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,256,034,367**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,256,034,367**

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Board Designated Reserve and TNE Analysis
As of June 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,116,170				
	Tier 1 - MetLife	158,842,359				
	Tier 1 - Wells Capital	159,246,689				
Board-designated Reserve						
		478,205,218	317,952,800	497,321,395	160,252,418	(19,116,177)
TNE Requirement	Tier 2 - MetLife	106,678,675	100,573,921	100,573,921	6,104,754	6,104,754
	Consolidated:	**584,883,893**	**418,526,722**	**597,895,316**	**166,357,172**	**(13,011,423)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

June 2020

Preliminary Report as of July 17, 2020

Final fiscal year report is subject to change following financial audit

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CalOptima - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
758,970	734,322	24,648	3.4%	Member Months	8,880,426	8,921,820	(41,394)	(0.5%)
328,701,248	296,642,702	32,058,546	10.8%	Revenues	3,840,846,316	3,565,765,952	275,080,365	7.7%
276,693,600	282,982,573	6,288,973	2.2%	Medical Expenses	3,644,418,430	3,399,334,013	(245,084,417)	(7.2%)
18,267,508	14,180,510	(4,086,998)	(28.8%)	Administrative Expenses	143,268,732	158,518,356	15,249,624	9.6%
33,740,140	**(520,381)**	**34,260,521**	**6583.7%**	**Operating Margin**	**53,159,154**	**7,913,583**	**45,245,571**	**571.7%**
(4,461,847)	1,250,000	(5,711,847)	(456.9%)	Non Operating Income (Loss)	35,302,415	15,000,000	20,302,415	135.3%
29,278,294	**729,619**	**28,548,674**	**3912.8%**	**Change in Net Assets**	**88,461,569**	**22,913,583**	**65,547,986**	**286.1%**
84.2%	95.4%	11.2%		Medical Loss Ratio	94.9%	95.3%	0.4%	
5.6%	4.8%	(0.8%)		Administrative Loss Ratio	3.7%	4.4%	0.7%	
10.3%	(0.2%)	10.4%		Operating Margin Ratio	1.4%	0.2%	1.2%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
				*Administrative Loss Ratio (excluding Directed Payments)	3.9%			

*CalOptima updated the category of Directed Payments per Department of Healthcare Services instructions

Preliminary

CalOptima
Financial Dashboard
For the Twelve Months Ended June 30, 2020

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	742,769	718,592	24,177	3.4%
OneCare Connect	14,358	13,780	578	4.2%
OneCare	1,452	1,520	(68)	(4.5%)
PACE	391	430	(39)	(9.1%)
Total	758,970	734,322	24,648	3.4%

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 21,540	$ 446	$ 21,094	4729.6%
OneCare Connect	3,721	(1,147)	4,868	424.4%
OneCare	746	(111)	857	772.1%
PACE	775	291	485	166.3%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	2,495	1,250	1,245	99.6%
Total	$ 29,277	$ 729	$ 28,548	3916.0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	84.9%	95.3%	10.4
OneCare Connect	81.0%	97.3%	16.4
OneCare	63.7%	97.6%	33.9

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 15,156	$ 12,066	$ (3,089)	(25.6%)
OneCare Connect	2,691	1,777	(915)	(51.5%)
OneCare	90	149	59	39.8%
PACE	331	189	(142)	(75.4%)
Total	$ 18,268	$ 14,181	$ (4,087)	(28.8%)

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,091	1,183	92
OneCare Connect	194	211	17
OneCare	10	9	(1)
PACE	83	94	11
Total	1,378	1,497	118

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	681	607	73
OneCare Connect	74	65	9
OneCare	143	163	(20)
PACE	5	5	0
Total	903	841	62

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	8,688,592	8,731,182	(42,590)	(0.5%)
OneCare Connect	169,728	167,957	1,771	1.1%
OneCare	17,552	18,081	(529)	(2.9%)
PACE	4,554	4,600	(46)	(1.0%)
Total	8,880,426	8,921,820	(41,394)	(0.5%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 39,483	$ 21,803	$ 17,680	81.1%
OneCare Connect	1,931	(15,019)	16,950	112.9%
OneCare	(1,566)	(1,332)	(234)	(17.6%)
PACE	5,586	2,462	3,124	126.9%
505 Bldg.	-	-	-	0.0%
Investment Income & Other	43,027	15,000	28,027	186.8%
Total	$ 88,461	$ 22,914	$ 65,547	286.1%

MLR

	Actual	Budget	% Point Var
Medi-Cal	95.2%	95.2%	(0.0)
OneCare Connect	93.1%	97.7%	4.7
OneCare	99.3%	97.8%	(1.6)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 119,383	$ 133,071	$ 13,688	10.3%
OneCare Connect	20,009	21,480	1,471	6.8%
OneCare	1,672	1,768	95	5.4%
PACE	2,204	2,200	(4)	(0.2%)
Total	$ 143,269	$ 158,518	$ 15,250	9.6%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	12,589	12,880	292
OneCare Connect	2,327	2,483	156
OneCare	116	112	(4)
PACE	896	1,108	212
Total	15,928	16,583	655

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	690	678	12
OneCare Connect	73	68	5
OneCare	152	162	(11)
PACE	5	4	1
Total	920	912	8

Preliminary

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	758,970		734,322		24,648	
REVENUE						
Medi-Cal	$ 289,088,519	$ 389.20	$ 268,039,886	$ 373.01	$ 21,048,633	$ 16.19
OneCare Connect	33,695,176	2,346.79	23,666,899	1,717.48	10,028,277	629.31
OneCare	2,304,646	1,587.22	1,609,747	1,059.04	694,899	528.18
PACE	3,612,906	9,240.17	3,326,170	7,735.28	286,736	1,504.89
Total Operating Revenue	328,701,248	433.09	296,642,702	403.97	32,058,546	29.12
MEDICAL EXPENSES						
Medi-Cal	245,435,691	330.43	255,527,105	355.59	10,091,415	25.16
OneCare Connect	27,282,573	1,900.17	23,037,192	1,671.78	(4,245,381)	(228.39)
OneCare	1,468,839	1,011.60	1,571,347	1,033.78	102,508	22.18
PACE	2,506,498	6,410.48	2,846,929	6,620.77	340,431	210.29
Total Medical Expenses	276,693,600	364.56	282,982,573	385.37	6,288,973	20.81
GROSS MARGIN	52,007,648	68.53	13,660,129	18.60	38,347,519	49.93
ADMINISTRATIVE EXPENSES						
Salaries and benefits	12,106,633	15.95	8,608,955	11.72	(3,497,678)	(4.23)
Professional fees	751,217	0.99	628,730	0.86	(122,487)	(0.13)
Purchased services	1,231,984	1.62	1,536,336	2.09	304,352	0.47
Printing & Postage	1,025,263	1.35	521,645	0.71	(503,618)	(0.64)
Depreciation & Amortization	326,507	0.43	457,866	0.62	131,359	0.19
Other expenses	2,485,936	3.28	2,053,030	2.80	(432,906)	(0.48)
Indirect cost allocation & Occupancy expense	339,969	0.45	373,948	0.51	33,979	0.06
Total Administrative Expenses	18,267,508	24.07	14,180,510	19.31	(4,086,998)	(4.76)
INCOME (LOSS) FROM OPERATIONS	33,740,140	44.46	(520,381)	(0.71)	34,260,521	45.17
INVESTMENT INCOME						
Interest income	1,354,415	1.78	1,250,000	1.70	104,415	0.08
Realized gain/(loss) on investments	598,836	0.79	-	-	598,836	0.79
Unrealized gain/(loss) on investments	541,956	0.71	-	-	541,956	0.71
Total Investment Income	2,495,206	3.29	1,250,000	1.70	1,245,206	1.59
TOTAL MCO TAX	(6,961,216)	(9.17)	-	-	(6,961,216)	(9.17)
TOTAL GRANT INCOME	4,163	0.01	-	-	4,163	0.01
CHANGE IN NET ASSETS	**29,278,294**	**38.58**	**729,619**	**0.99**	**28,548,674**	**37.59**
MEDICAL LOSS RATIO	**84.2%**		**95.4%**		**11.2%**	
ADMINISTRATIVE LOSS RATIO	**5.6%**		**4.8%**		**-0.8%**	

Preliminary

CalOptima - Consolidated
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2020

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	8,880,426		8,921,820		(41,394)	
REVENUE						
Medi-Cal	$ 3,469,816,350	$ 399.35	$ 3,223,902,036	$ 369.24	$ 245,914,314	$ 30.11
OneCare Connect	317,641,603	1,871.47	286,554,214	1,706.12	31,087,389	165.35
OneCare	15,950,203	908.74	19,619,684	1,085.10	(3,669,481)	(176.36)
PACE	37,438,160	8,220.94	35,690,018	7,758.70	1,748,142	462.24
Total Operating Revenue	3,840,846,316	432.51	3,565,765,952	399.67	275,080,365	32.84
MEDICAL EXPENSES						
Medi-Cal	3,303,225,031	380.18	3,069,028,403	351.50	(234,196,628)	(28.68)
OneCare Connect	295,701,390	1,742.21	280,093,119	1,667.65	(15,608,271)	(74.56)
OneCare	15,843,761	902.68	19,184,287	1,061.02	3,340,526	158.34
PACE	29,648,249	6,510.38	31,028,204	6,745.26	1,379,955	234.88
Total Medical Expenses	3,644,418,430	410.39	3,399,334,013	381.01	(245,084,417)	(29.38)
GROSS MARGIN	196,427,886	22.12	166,431,939	18.66	29,995,947	3.46
ADMINISTRATIVE EXPENSES						
Salaries and benefits	93,964,926	10.58	98,271,394	11.01	4,306,468	0.43
Professional fees	3,681,374	0.41	6,074,712	0.68	2,393,338	0.27
Purchased services	12,375,674	1.39	15,810,290	1.77	3,434,616	0.38
Printing & Postage	5,933,413	0.67	6,613,937	0.74	680,524	0.07
Depreciation & Amortization	4,189,457	0.47	5,494,392	0.62	1,304,935	0.15
Other expenses	19,052,193	2.15	21,684,574	2.43	2,632,380	0.28
Indirect cost allocation & Occupancy expense	4,071,694	0.46	4,569,057	0.51	497,363	0.05
Total Administrative Expenses	143,268,732	16.13	158,518,356	17.77	15,249,624	1.64
INCOME (LOSS) FROM OPERATIONS	53,159,154	5.99	7,913,583	0.89	45,245,571	5.10
INVESTMENT INCOME						
Interest income	29,129,757	3.28	15,000,000	1.68	14,129,757	1.60
Realized gain/(loss) on investments	4,474,700	0.50	-	-	4,474,700	0.50
Unrealized gain/(loss) on investments	9,422,973	1.06	-	-	9,422,973	1.06
Total Investment Income	43,027,431	4.85	15,000,000	1.68	28,027,431	3.17
TOTAL MCO TAX	(7,701,134)	(0.87)	-	-	(7,701,134)	(0.87)
TOTAL GRANT INCOME	(25,086)	-	-	-	(25,086)	-
OTHER INCOME	1,204	-	-	-	1,204	-
CHANGE IN NET ASSETS	**88,461,569**	**9.96**	**22,913,583**	**2.57**	**65,547,986**	**7.39**
MEDICAL LOSS RATIO	**94.9%**		**95.3%**		**0.4%**	
ADMINISTRATIVE LOSS RATIO	**3.7%**		**4.4%**		**0.7%**	

Preliminary

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended June 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	493,728	239,310	9,731	742,769	14,358	1,452	391	758,970
REVENUES								
Capitation Revenue	141,907,797	$ 125,406,472	$ 21,774,250	$ 289,088,519	$ 33,695,176	$ 2,304,646	$ 3,612,906	$ 328,701,248
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	141,907,797	125,406,472	21,774,250	289,088,519	33,695,176	2,304,646	3,612,906	328,701,248
MEDICAL EXPENSES								
Provider Capitation	59,640,544	54,862,921	(16,652,394)	97,851,071	15,934,115	676,242		114,461,429
Facilities	12,788,902	14,067,950	9,419,570	36,276,421	5,099,641	224,382	633,145	42,233,589
Professional Claims	21,193,493	11,634,436	1,323,720	34,151,649	988,320	51,043	654,586	35,845,598
Prescription Drugs	19,799,784	23,827,001	4,739,268	48,366,054	4,762,832	528,041	274,978	53,931,904
MLTSS	23,254,743	1,685,770	1,303,298	26,243,811	687,032	(802)	13,157	26,943,198
Medical Management	2,653,928	1,299,437	2,286,711	6,240,076	900,082	(10,066)	887,982	8,018,073
Quality Incentives	(3,118,416)	(1,782,129)	21,241	(4,879,304)	(1,166,429)		4,888	(6,040,845)
Reinsurance & Other	517,033	646,131	22,748	1,185,912	76,979		37,763	1,300,655
Total Medical Expenses	136,730,011	106,241,517	2,464,162	245,435,691	27,282,573	1,468,839	2,506,498	276,693,600
Medical Loss Ratio	96.4%	84.7%	11.3%	84.9%	81.0%	63.7%	69.4%	84.2%
GROSS MARGIN	**5,177,785**	**19,164,955**	**19,310,088**	**43,652,829**	**6,412,604**	**835,807**	**1,106,409**	**52,007,648**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				11,096,456	779,910	79,577	150,690	12,106,633
Professional fees				732,094	4,000	15,000	123	751,217
Purchased services				881,436	225,160	9,614	115,774	1,231,984
Printing & Postage				790,157	185,564	28,182	21,360	1,025,263
Depreciation & Amortization				324,423			2,084	326,507
Other expenses				2,378,790	73,466	0	33,679	2,485,936
Indirect cost allocation & Occupancy				(1,047,673)	1,423,110	(42,723)	7,255	339,969
Total Administrative Expenses				15,155,683	2,691,211	89,650	330,965	18,267,508
Admin Loss Ratio				5.2%	8.0%	3.9%	9.2%	5.6%
INCOME (LOSS) FROM OPERATIONS				28,497,146	3,721,393	746,157	775,444	33,740,140
INVESTMENT INCOME								2,495,206
TOTAL MCO TAX				(6,961,216)				(6,961,216)
TOTAL GRANT INCOME				4,163				4,163
CHANGE IN NET ASSETS				**$ 21,540,093**	**$ 3,721,393**	**$ 746,157**	**$ 775,444**	**$ 29,278,294**
BUDGETED CHANGE IN NET ASSETS				446,374	(1,146,835)	(110,516)	290,596	729,619
VARIANCE TO BUDGET - FAV (UNFAV)				$ 21,093,719	$ 4,868,228	$ 856,673	$ 484,848	$ 28,548,674

Preliminary

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2020

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
MEMBER MONTHS	5,803,227	2,750,362	135,003	8,688,592	169,728	17,552	4,554	8,880,426
REVENUES								
Capitation Revenue	1,850,343,850	$ 1,353,042,662	$ 266,429,838	$ 3,469,816,350	$ 317,641,603	$ 15,950,203	$ 37,438,160	$ 3,840,846,316
Other Income	-	-	-	-	-	-	-	-
Total Operating Revenue	1,850,343,850	1,353,042,662	266,429,838	3,469,816,350	317,641,603	15,950,203	37,438,160	3,840,846,316
MEDICAL EXPENSES								
Provider Capitation	490,100,071	539,906,373	90,694,618	1,120,701,061	141,771,206	3,935,575		1,266,407,842
Facilities	277,007,939	240,295,754	65,568,204	582,871,897	45,786,599	4,531,638	7,927,259	641,117,393
Professional Claims	213,790,814	88,801,810	17,128,121	319,720,744	9,248,846	604,754	6,900,555	336,474,899
Prescription Drugs	234,949,247	251,353,806	67,605,169	553,908,222	67,914,328	6,059,170	3,008,033	630,889,753
MLTSS	402,056,900	30,655,819	19,589,781	452,302,501	15,287,975	278,046	364,249	468,232,771
Medical Management	25,993,472	15,294,686	5,103,081	46,391,239	12,782,941	434,579	8,978,618	68,587,376
Quality Incentives	7,311,432	3,504,834	1,583,079	12,399,345	1,052,071		211,135	13,662,551
Reinsurance & Other	123,730,950	90,829,385	369,687	214,930,022	1,857,424		2,258,400	219,045,846
Total Medical Expenses	1,774,940,823	1,260,642,466	267,641,741	3,303,225,031	295,701,390	15,843,761	29,648,249	3,644,418,430
Medical Loss Ratio	95.9%	93.2%	100.5%	95.2%	93.1%	99.3%	79.2%	94.9%
GROSS MARGIN	**75,403,026**	**92,400,196**	**(1,211,903)**	**166,591,319**	**21,940,213**	**106,443**	**7,789,911**	**196,427,886**
ADMINISTRATIVE EXPENSES								
Salaries & Benefits				82,645,413	8,771,602	841,525	1,706,386	93,964,926
Professional fees				2,964,642	495,486	219,371	1,876	3,681,374
Purchased services				10,322,812	1,690,483	145,390	216,989	12,375,674
Printing & Postage				4,662,274	1,064,238	84,194	122,707	5,933,413
Depreciation & Amortization				4,164,453			25,004	4,189,457
Other expenses				18,541,509	431,553	2,473	76,659	19,052,193
Indirect cost allocation & Occupancy				(3,918,235)	7,556,059	379,423	54,446	4,071,694
Total Administrative Expenses				119,382,868	20,009,421	1,672,376	2,204,067	143,268,732
Admin Loss Ratio				3.4%	6.3%	10.5%	5.9%	3.7%
INCOME (LOSS) FROM OPERATIONS				47,208,451	1,930,792	(1,565,934)	5,585,845	53,159,154
INVESTMENT INCOME								43,027,431
TOTAL MCO TAX				(7,701,134)				(7,701,134)
TOTAL GRANT INCOME				(25,086)				(25,086)
OTHER INCOME				1,204				1,204
CHANGE IN NET ASSETS				**$ 39,483,435**	**$ 1,930,792**	**$ (1,565,934)**	**$ 5,585,845**	**$ 88,461,569**
BUDGETED CHANGE IN NET ASSETS				21,802,995	(15,018,833)	(1,332,400)	2,461,821	22,913,583
VARIANCE TO BUDGET - FAV (UNFAV)				$ 17,680,440	$ 16,949,625	$ (233,534)	$ 3,124,024	$ 65,547,986

Preliminary

June 30, 2020 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $29.3 million, $28.5 million favorable to budget
- Operating surplus is $33.7 million, with a deficit in non-operating income of $4.5 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $88.5 million, $65.5 million favorable to budget
- Operating surplus is $53.2 million, with a surplus in non-operating income of $35.3 million

Change in Net Assets by Line of Business (LOB) ($ millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
28.5	0.4	28.1	Medi-Cal	47.2	21.8	25.4
3.7	(1.1)	4.9	OCC	1.9	(15.0)	16.9
0.7	(0.1)	0.9	OneCare	(1.6)	(1.3)	(0.2)
0.8	0.3	0.5	PACE	5.6	2.5	3.1
33.7	**(0.5)**	**34.2**	**Operating**	**53.2**	**7.9**	**45.2**
(4.5)	1.3	(5.7)	Inv./Rental Inc, MCO tax	35.3	15.0	20.3
(4.5)	**1.3**	**(5.7)**	**Non-Operating**	**35.3**	**15.0**	**20.3**
29.3	**0.7**	**28.5**	**TOTAL**	**88.5**	**22.9**	**65.5**

Enrollment Summary
For the Twelve Months Ended June 30, 2020

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
66,968	66,635	333	0.5%	Aged	793,520	790,941	2,579	0.3%
504	615	(111)	(18.0%)	BCCTP	6,296	7,380	(1,084)	(14.7%)
45,215	43,483	1,732	4.0%	Disabled	538,131	524,091	14,040	2.7%
286,183	272,626	13,557	5.0%	TANF Child	3,385,815	3,360,691	25,124	0.7%
91,340	82,881	8,459	10.2%	TANF Adult	1,037,554	1,025,650	11,904	1.2%
3,518	3,404	114	3.3%	LTC	41,910	40,848	1,062	2.6%
239,310	236,008	3,302	1.4%	MCE	2,750,362	2,826,301	(75,939)	(2.7%)
9,731	12,940	(3,209)	(24.8%)	WCM	135,003	155,280	(20,277)	(13.1%)
742,769	**718,592**	**24,177**	**3.4%**	**Medi-Cal Total**	**8,688,592**	**8,731,182**	**(42,590)**	**(0.5%)**
14,358	**13,780**	**578**	**4.2%**	**OneCare Connect**	**169,728**	**167,957**	**1,771**	**1.1%**
1,452	**1,520**	**(68)**	**(4.5%)**	**OneCare**	**17,552**	**18,081**	**(529)**	**(2.9%)**
391	**430**	**(39)**	**(9.1%)**	**PACE**	**4,554**	**4,600**	**(46)**	**(1.0%)**
758,970	**734,322**	**24,648**	**3.4%**	**CalOptima Total**	**8,880,426**	**8,921,820**	**(41,394)**	**(0.5%)**
				Enrollment (by Network)				
167,019	159,577	7,442	4.7%	HMO	1,922,214	1,937,644	(15,430)	(0.8%)
211,959	203,424	8,535	4.2%	PHC	2,475,787	2,490,998	(15,211)	(0.6%)
178,285	183,766	(5,481)	(3.0%)	Shared Risk Group	2,108,450	2,235,816	(127,366)	(5.7%)
185,506	171,825	13,681	8.0%	Fee for Service	2,182,140	2,066,724	115,416	5.6%
742,769	**718,592**	**24,177**	**3.4%**	**Medi-Cal Total**	**8,688,592**	**8,731,182**	**(42,590)**	**(0.5%)**
14,358	**13,780**	**578**	**4.2%**	**OneCare Connect**	**169,728**	**167,957**	**1,771**	**1.1%**
1,452	**1,520**	**(68)**	**(4.5%)**	**OneCare**	**17,552**	**18,081**	**(529)**	**(2.9%)**
391	**430**	**(39)**	**(9.1%)**	**PACE**	**4,554**	**4,600**	**(46)**	**(1.0%)**
758,970	**734,322**	**24,648**	**3.4%**	**CalOptima Total**	**8,880,426**	**8,921,820**	**(41,394)**	**(0.5%)**

CalOptima
Enrollment Trend by Network
Fiscal Year 2020

	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	YTD Actual	YTD Budget	Variance
HMOs															
Aged	3,723	3,740	3,754	3,821	3,827	3,743	3,768	3,625	3,679	3,746	3,770	3,776	44,972	45,493	(521)
BCCTP	1	1	2	2	1	1	1	1	1	1	1	1	14	12	2
Disabled	6,539	6,547	6,572	6,613	6,633	6,546	6,468	6,612	6,670	6,713	6,742	6,739	79,394	79,679	(285)
TANF Child	54,046	53,703	52,620	53,069	52,791	51,642	50,877	50,743	51,816	52,360	53,207	54,110	630,984	627,909	3,075
TANF Adult	27,944	27,740	27,446	27,279	27,012	27,168	25,104	25,208	25,961	26,474	27,420	28,364	323,120	329,707	(6,587)
LTC	2	1	3	3	2	4		5	1	1	3	3	28	24	4
MCE	68,973	69,077	68,729	68,881	68,361	68,256	62,418	66,229	67,457	69,104	70,666	72,254	820,405	826,464	(6,059)
WCM	2,026	2,087	2,052	1,987	2,006	2,024	1,692	1,937	1,894	1,912	1,908	1,772	23,297	28,356	(5,059)
Total	**163,254**	**162,896**	**161,178**	**161,655**	**160,633**	**159,384**	**150,328**	**154,360**	**157,479**	**160,311**	**163,717**	**167,019**	**1,922,214**	**1,937,644**	**(15,430)**
PHCs															
Aged	1,548	1,540	1,524	1,542	1,577	1,579	1,516	1,448	1,474	1,493	1,539	1,562	18,342	18,183	159
BCCTP													-		0
Disabled	5,416	5,499	5,323	5,425	5,500	5,474	5,244	5,422	5,436	5,482	5,497	5,519	65,237	63,904	1,333
TANF Child	148,665	148,131	143,994	146,390	145,734	140,237	143,833	140,195	142,951	144,407	146,437	148,550	1,739,524	1,745,744	(6,220)
TANF Adult	11,149	11,322	10,925	10,865	10,743	11,285	9,797	9,907	10,366	10,489	10,846	11,339	129,033	118,727	10,306
LTC			1		1	1	2	2	1			1	9		9
MCE	37,510	37,479	37,084	37,037	36,728	36,708	33,716	35,640	36,168	36,723	37,741	38,812	441,346	452,232	(10,886)
WCM	7,209	7,276	7,190	7,151	7,070	6,994	6,371	6,803	6,763	6,713	6,580	6,176	82,296	92,208	(9,912)
Total	**211,497**	**211,247**	**206,041**	**208,410**	**207,353**	**202,278**	**200,479**	**199,417**	**203,159**	**205,307**	**208,640**	**211,959**	**2,475,787**	**2,490,998**	**(15,211)**
Shared Risk Groups															
Aged	3,569	3,523	3,470	3,501	3,527	3,364	3,301	3,225	3,223	3,226	3,276	3,324	40,529	43,502	(2,973)
BCCTP						1	(1)	1					1		1
Disabled	7,275	7,294	7,144	7,177	7,200	7,139	6,724	7,092	7,010	6,980	7,020	7,015	85,070	81,128	3,942
TANF Child	63,291	62,381	57,001	59,579	58,690	56,771	56,508	54,614	55,822	56,162	57,113	58,229	696,161	731,188	(35,027)
TANF Adult	28,681	28,390	27,842	27,428	26,946	27,269	24,473	24,861	25,641	26,092	27,224	28,377	323,224	338,410	(15,186)
LTC	1	3	3	2	1	1		1	1			1	14	12	2
MCE	84,595	83,922	82,492	81,749	80,096	79,714	69,637	73,826	74,815	76,187	78,198	80,375	945,606	1,017,972	(72,366)
WCM	1,732	1,706	1,620	1,598	1,581	1,593	1,367	1,457	1,470	1,436	1,321	964	17,845	23,604	(5,759)
Total	**189,144**	**187,219**	**179,572**	**181,034**	**178,041**	**175,852**	**162,009**	**165,077**	**167,982**	**170,083**	**174,152**	**178,285**	**2,108,450**	**2,235,816**	**(127,366)**
Fee for Service (Dual)															
Aged	51,730	52,454	52,097	52,050	52,649	51,770	54,711	52,919	52,855	53,118	53,097	53,176	632,626	629,069	3,557
BCCTP	15	18	17	18	19	20	13	10	12	12	18	11	183	216	(33)
Disabled	20,752	20,053	20,586	20,577	20,781	20,848	20,986	20,729	21,085	20,778	20,714	20,861	248,750	246,047	2,703
TANF Child		19	1	1	1	1	1	1	1	1	1	1	29		29
TANF Adult	964	1,923	949	941	963	938	1,528	917	847	834	883	901	12,588	10,370	2,218
LTC	3,044	3,097	3,061	3,161	3,204	2,971	3,389	3,142	3,157	3,192	3,138	3,170	37,726	36,588	1,138
MCE	2,116	2,171	1,935	1,717	1,737	2,255	876	1,084	1,135	1,144	1,278	1,467	18,915	24,780	(5,865)
WCM	15	15	15	16	15	16	15	14	13	13	14	15	176	192	(16)
Total	**78,636**	**79,750**	**78,661**	**78,481**	**79,369**	**78,819**	**81,519**	**78,816**	**79,105**	**79,092**	**79,143**	**79,602**	**950,993**	**947,262**	**3,731**
Fee for Service (Non-Dual - Total)															
Aged	4,682	4,211	4,370	4,583	4,890	3,841	4,864	5,163	5,011	5,189	5,117	5,130	57,051	54,694	2,357
BCCTP	550	542	484	532	525	518	506	473	489	500	487	492	6,098	7,152	(1,054)
Disabled	4,928	5,692	4,374	4,930	5,428	8,670	483	5,084	4,908	5,105	4,997	5,081	59,680	53,333	6,347
TANF Child	25,571	32,106	16,125	25,295	29,914	21,194	32,748	29,586	27,971	27,997	25,317	25,293	319,117	255,850	63,267
TANF Adult	19,658	19,951	19,512	19,854	23,011	22,542	18,203	21,106	20,816	21,023	21,554	22,359	249,589	228,436	21,153
LTC	328	326	331	347	364	302	358	359	359	365	351	343	4,133	4,224	(91)
MCE	40,680	41,152	40,342	41,308	48,994	48,138	37,208	44,795	45,007	45,308	44,756	46,402	524,090	504,853	19,237
WCM	843	960	978	1,008	1,079	874	936	1,043	1,022	956	886	804	11,389	10,920	469
Total	**97,240**	**104,940**	**86,516**	**97,857**	**114,205**	**106,079**	**95,306**	**107,609**	**105,583**	**106,443**	**103,465**	**105,904**	**1,231,147**	**1,119,462**	**111,685**
Grand Totals															
Aged	65,252	65,468	65,215	65,497	66,470	64,297	68,160	66,380	66,242	66,772	66,799	66,968	793,520	790,941	2,579
BCCTP	566	561	503	552	545	540	519	485	502	513	506	504	6,296	7,380	(1,084)
Disabled	44,910	45,085	43,999	44,722	45,542	48,677	39,905	44,939	45,109	45,058	44,970	45,215	538,131	524,091	14,040
TANF Child	291,573	296,340	269,741	284,334	287,130	269,845	283,967	275,139	278,561	280,927	282,075	286,183	3,385,815	3,360,691	25,124
TANF Adult	88,396	89,326	86,674	86,367	88,675	89,202	79,105	81,999	83,631	84,912	87,927	91,340	1,037,554	1,025,650	11,904
LTC	3,375	3,427	3,399	3,513	3,572	3,279	3,749	3,509	3,519	3,558	3,492	3,518	41,910	40,848	1,062
MCE	233,874	233,801	230,582	230,692	235,916	235,071	203,855	221,574	224,582	228,466	232,639	239,310	2,750,362	2,826,301	(75,939)
WCM	11,825	12,044	11,855	11,760	11,751	11,501	10,381	11,254	11,162	11,030	10,709	9,731	135,003	155,280	(20,277)
Total MediCal MM	**739,771**	**746,052**	**711,968**	**727,437**	**739,601**	**722,412**	**689,641**	**705,279**	**713,308**	**721,236**	**729,117**	**742,769**	**8,688,592**	**8,731,182**	**(42,590)**
OneCare Connect	**14,257**	**14,090**	**14,186**	**14,093**	**14,065**	**14,264**	**14,104**	**14,171**	**14,077**	**14,151**	**13,912**	**14,358**	**169,728**	**167,957**	**1,771**
OneCare	**1,530**	**1,545**	**1,564**	**1,567**	**1,498**	**1,465**	**1,417**	**1,382**	**1,364**	**1,364**	**1,404**	**1,452**	**17,552**	**18,081**	**(529)**
PACE	**335**	**345**	**356**	**368**	**375**	**393**	**394**	**396**	**400**	**403**	**398**	**391**	**4,554**	**4,600**	**(46)**
Grand Total	**755,893**	**762,032**	**728,074**	**743,465**	**755,539**	**738,534**	**705,556**	**721,228**	**729,149**	**737,154**	**744,831**	**758,970**	**8,880,426**	**8,921,820**	**(41,394)**

Preliminary

ENROLLMENT:

Overall, June enrollment was 758,970

- Favorable to budget 24,648 or 3.4%
- Increased 14,139 or 1.9% from prior month (PM) (May 2020)
- Decreased 953 or 0.1% from prior year (PY) (June 2019)

Medi-Cal enrollment was 742,769

- Favorable to budget 24,177 or 3.4% primarily due to COVID-19
  - Temporary Assistance for Needy Families (TANF) favorable 22,016
  - Medi-Cal Expansion (MCE) favorable 3,302
  - Seniors and Persons with Disabilities (SPD) favorable 1,954
  - Long-Term Care (LTC) favorable 114
  - Whole Child Model (WCM) unfavorable 3,209
- Increased 13,652 from PM

OneCare Connect enrollment was 14,358

- Favorable to budget 578 or 4.2%
- Increased 446 from PM

OneCare enrollment was 1,452

- Unfavorable to budget 68 or 4.5%
- Increased 48 from PM

PACE enrollment was 391

- Unfavorable to budget 39 or 9.1%
- Decreased 7 from PM

CalOptima
Medi-Cal Total
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
742,769	**718,592**	**24,177**	**3.4%**	**Member Months**	**8,688,592**	**8,731,182**	**(42,590)**	**(0.5%)**
				Revenues				
289,088,519	268,039,886	21,048,633	7.9%	Capitation Revenue	3,469,816,350	3,223,902,036	245,914,314	7.6%
-	-	-	0.0%	Other Income	-	-	-	0.0%
289,088,519	**268,039,886**	**21,048,633**	**7.9%**	**Total Operating Revenue**	**3,469,816,350**	**3,223,902,036**	**245,914,314**	**7.6%**
				Medical Expenses				
92,971,768	94,994,969	2,023,201	2.1%	Provider Capitation	1,133,100,406	1,140,979,501	7,879,096	0.7%
36,276,421	48,126,242	11,849,820	24.6%	Facilities Claims	582,871,897	580,056,805	(2,815,092)	(0.5%)
34,151,649	23,082,986	(11,068,663)	(48.0%)	Professional Claims	319,720,744	277,901,758	(41,818,986)	(15.0%)
48,366,054	43,398,729	(4,967,324)	(11.4%)	Prescription Drugs	553,908,222	526,829,964	(27,078,258)	(5.1%)
26,243,811	36,726,003	10,482,192	28.5%	MLTSS	452,302,501	444,867,770	(7,434,731)	(1.7%)
6,240,076	5,961,818	(278,258)	(4.7%)	Medical Management	46,391,239	59,863,238	13,471,999	22.5%
1,185,912	3,236,358	2,050,446	63.4%	Reinsurance & Other	214,930,022	38,529,366	(176,400,656)	(457.8%)
245,435,691	**255,527,105**	**10,091,415**	**3.9%**	**Total Medical Expenses**	**3,303,225,031**	**3,069,028,403**	**(234,196,628)**	**(7.6%)**
43,652,829	**12,512,781**	**31,140,048**	**248.9%**	**Gross Margin**	**166,591,319**	**154,873,633**	**11,717,686**	**7.6%**
				Administrative Expenses				
11,096,456	7,539,014	(3,557,442)	(47.2%)	Salaries, Wages & Employee Benefits	82,645,413	85,950,466	3,305,053	3.8%
732,094	529,312	(202,782)	(38.3%)	Professional Fees	2,964,642	4,881,576	1,916,934	39.3%
881,436	1,357,317	475,881	35.1%	Purchased Services	10,322,812	13,062,021	2,739,209	21.0%
790,157	398,588	(391,569)	(98.2%)	Printing and Postage	4,662,274	5,137,217	474,943	9.2%
324,423	455,750	131,327	28.8%	Depreciation & Amortization	4,164,453	5,469,000	1,304,547	23.9%
2,378,790	1,972,272	(406,518)	(20.6%)	Other Operating Expenses	18,541,509	20,715,433	2,173,924	10.5%
(1,047,673)	(185,846)	861,827	463.7%	Indirect Cost Allocation, Occupancy Expense	(3,918,235)	(2,145,075)	1,773,160	82.7%
15,155,683	**12,066,407**	**(3,089,276)**	**(25.6%)**	**Total Administrative Expenses**	**119,382,868**	**133,070,638**	**13,687,770**	**10.3%**
				Operating Tax				
9,923,422	11,082,710	(1,159,288)	(10.5%)	Tax Revenue	67,109,004	134,629,900	(67,520,896)	(50.2%)
16,884,638	11,082,710	(5,801,928)	(52.4%)	Premium Tax Expense	74,810,138	134,629,900	59,819,762	44.4%
-	-	-	0.0%	Sales Tax Expense	-	-	-	0.0%
(6,961,216)	-	(6,961,216)	**0.0%**	**Total Net Operating Tax**	(7,701,134)	-	(7,701,134)	**0.0%**
				Grant Income				
27,750	-	27,750	0.0%	Grant Revenue	314,218	-	314,218	0.0%
23,588	-	(23,588)	0.0%	Grant expense - Service Partner	236,838	-	(236,838)	0.0%
-	-	-	0.0%	Grant expense - Administrative	102,466	-	(102,466)	0.0%
4,163	-	4,163	**0.0%**	**Total Grant Income**	(25,086)	-	(25,086)	**0.0%**
-	**-**	**-**	**0.0%**	**Other income**	**1,204**	**-**	**1,204**	**0.0%**
21,540,093	**446,374**	**21,093,719**	**4725.6%**	**Change in Net Assets**	**39,483,435**	**21,802,995**	**17,680,440**	**81.1%**
84.9%	***95.3%***	***10.4%***	***10.9%***	***Medical Loss Ratio***	***95.2%***	***95.2%***	***(0.0%)***	***(0.0%)***
5.2%	***4.5%***	***(0.7%)***	***(16.5%)***	***Admin Loss Ratio***	***3.4%***	***4.1%***	***0.7%***	***16.6%***

Preliminary

MEDI-CAL INCOME STATEMENT – JUNE MONTH:

REVENUES of $289.1 million are favorable to budget $21.0 million driven by:

- Favorable volume related variance of $9.0 million
- Favorable price related variance of $12.0 million due to:
  - $48.8 million of Proposition 56 revenue due to program expansion
  - $44.0 million of Intergovernmental Transfers (IGT) 9 revenue recognized in current month
  - $3.0 million of LTC revenue from non-LTC categories of aid
  - Offset by unfavorable $67.0 million of revenue due to Governor's budget changes, including
    - Gross Medical Expenditures (GME) risk corridor reserve
    - 1.5% Reduction to fiscal year (FY) 2020 capitation rates for certain aid code categories
  - Unfavorable $14.8 million of Coordinated Care Initiative (CCI) revenue due to risk corridor and re-evaluation of PY reserves
  - Unfavorable $2.6 million of WCM revenue

MEDICAL EXPENSES of $245.4 million are favorable to budget $10.1 million driven by:

- Unfavorable volume related variance of $8.6 million
- Favorable price related variance of $18.7 million due to:
  - Facilities Claims expense favorable variance of $13.5 million due to decreased utilization during COVID-19 pandemic
  - MLTSS expense favorable variance of $11.7 million due to decreased utilization during COVID-19 pandemic
  - Provider Capitation expense favorable variance of $5.2 million due to WCM and release of PY quality incentive accruals
  - Reinsurance & Other expense favorable variance of $2.2 million due to decreased utilization of non-medical transportation during COVID-19 pandemic
  - Offset by Professional Claims expense unfavorable variance of $10.3 million due to Proposition 56
  - Prescription Drugs expense unfavorable variance of $3.5 million due to increased utilization

MEDI-CAL INCOME STATEMENT – JUNE MONTH: (cont.)

ADMINISTRATIVE EXPENSES of $15.2 million are unfavorable to budget $3.1 million driven by:

- Salaries & Benefit expense unfavorable to budget $3.6 million due to annual true-up to the CalPERS actuarial report
- Other Non-Salary expense favorable to budget $0.5 million

CHANGE IN NET ASSETS is $21.5 million for the month, favorable to budget $21.1 million

CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Twelve Months Ended June 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,358	**13,780**	**578**	**4.2%**	**Member Months**	**169,728**	**167,957**	**1,771**	**1.1%**
				Revenues				
2,273,120	2,695,353	(422,233)	(15.7%)	Medi-Cal Capitation Revenue	29,923,839	33,043,899	(3,120,060)	(9.4%)
24,774,015	16,201,813	8,572,202	52.9%	Medicare Capitation Revenue Part C	221,662,510	195,995,597	25,666,913	13.1%
6,648,042	4,769,733	1,878,309	39.4%	Medicare Capitation Revenue Part D	66,055,255	57,514,718	8,540,537	14.8%
-	-	-	0.0%	Other Income	-	-	-	0.0%
33,695,176	**23,666,899**	**10,028,277**	**42.4%**	**Total Operating Revenue**	**317,641,603**	**286,554,214**	**31,087,389**	**10.8%**
				Medical Expenses				
14,767,687	10,676,222	(4,091,464)	(38.3%)	Provider Capitation	142,823,277	130,621,834	(12,201,443)	(9.3%)
5,099,641	3,507,527	(1,592,114)	(45.4%)	Facilities Claims	45,786,599	42,160,254	(3,626,345)	(8.6%)
988,320	694,213	(294,107)	(42.4%)	Ancillary	9,248,846	8,269,751	(979,095)	(11.8%)
687,032	1,472,807	785,775	53.4%	MLTSS	15,287,975	18,355,502	3,067,527	16.7%
4,762,832	5,276,777	513,945	9.7%	Prescription Drugs	67,914,328	64,498,845	(3,415,483)	(5.3%)
900,082	1,185,579	285,497	24.1%	Medical Management	12,782,941	13,549,358	766,417	5.7%
76,979	224,067	147,088	65.6%	Other Medical Expenses	1,857,424	2,637,575	780,151	29.6%
27,282,573	**23,037,192**	**(4,245,381)**	**(18.4%)**	**Total Medical Expenses**	**295,701,390**	**280,093,119**	**(15,608,271)**	**(5.6%)**
6,412,604	**629,707**	**5,782,897**	**918.3%**	**Gross Margin**	**21,940,213**	**6,461,095**	**15,479,118**	**239.6%**
				Administrative Expenses				
779,910	868,236	88,326	10.2%	Salaries, Wages & Employee Benefits	8,771,602	9,980,045	1,208,443	12.1%
4,000	77,795	73,795	94.9%	Professional Fees	495,486	933,550	438,064	46.9%
225,160	142,991	(82,169)	(57.5%)	Purchased Services	1,690,483	2,315,867	625,384	27.0%
185,564	95,857	(89,707)	(93.6%)	Printing and Postage	1,064,238	1,150,320	86,082	7.5%
73,466	71,871	(1,595)	(2.2%)	Other Operating Expenses	431,553	862,642	431,089	50.0%
1,423,110	519,792	(903,318)	(173.8%)	Indirect Cost Allocation	7,556,059	6,237,504	(1,318,555)	(21.1%)
2,691,211	**1,776,542**	**(914,669)**	**(51.5%)**	**Total Administrative Expenses**	**20,009,421**	**21,479,928**	**1,470,507**	**6.8%**
3,721,393	**(1,146,835)**	**4,868,228**	**424.5%**	**Change in Net Assets**	**1,930,792**	**(15,018,833)**	**16,949,625**	**112.9%**
81.0%	***97.3%***	***16.4%***	***16.8%***	***Medical Loss Ratio***	***93.1%***	***97.7%***	***4.7%***	***4.8%***
8.0%	***7.5%***	***(0.5%)***	***(6.4%)***	***Admin Loss Ratio***	***6.3%***	***7.5%***	***1.2%***	***16.0%***

ONECARE CONNECT INCOME STATEMENT– JUNE MONTH:

REVENUES of $33.7 million are favorable to budget $10.0 million driven by:

- Favorable volume related variance of $1.0 million
- Favorable price related variance of $9.0 million due to Centers for Medicare & Medicaid Services (CMS) calendar year (CY) 2020 mid-year Hierarchical Condition Category (HCC) reconciliation

MEDICAL EXPENSES of $27.3 million are unfavorable to budget $4.2 million driven by:

- Unfavorable volume related variance of $1.0 million
- Unfavorable price related variance of $3.3 million due to:
  - Provider Capitation expense unfavorable variance of $3.6 million due to CY 2020 mid-year HCC reconciliation
  - Facilities Claims expense unfavorable variance of $1.4 million due to increased utilization during COVID-19 pandemic
  - MLTSS expense favorable variance of $0.8 million
  - Prescription Drugs expense favorable variance of $0.7 million

ADMINISTRATIVE EXPENSES of $2.7 million are unfavorable to budget $0.9 million

CHANGE IN NET ASSETS is $3.7 million, favorable to budget $4.9 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,452	**1,520**	**(68)**	**(4.5%)**	**Member Months**	**17,552**	**18,081**	**(529)**	**(2.9%)**
				Revenues				
1,667,459	1,086,914	580,545	53.4%	Medicare Part C revenue	9,692,546	13,369,678	(3,677,132)	(27.5%)
637,187	522,833	114,354	21.9%	Medicare Part D revenue	6,257,658	6,250,006	7,652	0.1%
2,304,646	**1,609,747**	**694,899**	**43.2%**	**Total Operating Revenue**	**15,950,203**	**19,619,684**	**(3,669,481)**	**(18.7%)**
				Medical Expenses				
676,242	421,022	(255,220)	(60.6%)	Provider Capitation	3,935,575	5,238,065	1,302,490	24.9%
224,382	501,017	276,635	55.2%	Inpatient	4,531,638	6,060,455	1,528,817	25.2%
51,043	54,761	3,718	6.8%	Ancillary	604,754	662,044	57,290	8.7%
(802)	44,968	45,770	101.8%	Skilled Nursing Facilities	278,046	543,822	265,776	48.9%
528,041	489,456	(38,585)	(7.9%)	Prescription Drugs	6,059,170	5,972,830	(86,340)	(1.4%)
(10,066)	49,152	59,218	120.5%	Medical Management	434,579	576,572	141,993	24.6%
-	10,971	10,971	100.0%	Other Medical Expenses	-	130,499	130,499	100.0%
1,468,839	**1,571,347**	**102,508**	**6.5%**	**Total Medical Expenses**	**15,843,761**	**19,184,287**	**3,340,526**	**17.4%**
835,807	**38,400**	**797,407**	**2076.6%**	**Gross Margin**	**106,443**	**435,397**	**(328,954)**	**(75.6%)**
				Administrative Expenses				
79,577	53,406	(26,171)	(49.0%)	Salaries, wages & employee benefits	841,525	621,380	(220,145)	(35.4%)
15,000	21,470	6,470	30.1%	Professional fees	219,371	257,750	38,379	14.9%
9,614	17,057	7,443	43.6%	Purchased services	145,390	204,750	59,360	29.0%
28,182	16,663	(11,519)	(69.1%)	Printing and postage	84,194	200,000	115,806	57.9%
0	4,732	4,732	100.0%	Other operating expenses	2,473	56,850	54,377	95.7%
(42,723)	35,588	78,311	220.0%	Indirect cost allocation, occupancy expens	379,423	427,067	47,644	11.2%
89,650	**148,916**	**59,266**	**39.8%**	**Total Administrative Expenses**	**1,672,376**	**1,767,797**	**95,421**	**5.4%**
746,157	**(110,516)**	**856,673**	**775.2%**	**Change in Net Assets**	**(1,565,934)**	**(1,332,400)**	**(233,534)**	**(17.5%)**
63.7%	***97.6%***	***33.9%***	***34.7%***	***Medical Loss Ratio***	***99.3%***	***97.8%***	***(1.6%)***	***(1.6%)***
3.9%	***9.3%***	***5.4%***	***58.0%***	***Admin Loss Ratio***	***10.5%***	***9.0%***	***(1.5%)***	***(16.4%)***

CalOptima
PACE
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
391	**430**	**(39)**	**(9.1%)**	**Member Months**	**4,554**	**4,600**	**(46)**	**-1.0%**
				Revenues				
2,235,541	2,586,442	(350,901)	(13.6%)	Medi-Cal Capitation Revenue	28,621,072	27,657,461	963,611	3.5%
1,167,353	581,345	586,008	100.8%	Medicare Part C Revenue	6,910,677	6,335,866	574,811	9.1%
210,013	158,383	51,630	32.6%	Medicare Part D Revenue	1,906,412	1,696,691	209,721	12.4%
3,612,906	**3,326,170**	**286,736**	**8.6%**	**Total Operating Revenue**	**37,438,160**	**35,690,018**	**1,748,142**	**4.9%**
				Medical Expenses				
887,982	924,359	36,377	3.9%	Medical Management	8,978,618	10,603,897	1,625,279	15.3%
633,145	637,626	4,481	0.7%	Facilities Claims	7,927,259	6,777,283	(1,149,976)	(17.0%)
654,586	682,599	28,013	4.1%	Professional Claims	6,900,555	7,378,977	478,422	6.5%
37,763	287,634	249,871	86.9%	Patient Transportation	2,258,400	3,000,793	742,393	24.7%
274,978	260,979	(13,999)	(5.4%)	Prescription Drugs	3,008,033	2,811,394	(196,639)	(7.0%)
13,157	47,066	33,909	72.0%	MLTSS	364,249	375,860	11,611	3.1%
4,888	6,666	1,779	26.7%	Other Expenses	211,135	80,000	(131,135)	(163.9%)
2,506,498	**2,846,929**	**340,431**	**12.0%**	**Total Medical Expenses**	**29,648,249**	**31,028,204**	**1,379,955**	**4.4%**
1,106,409	**479,241**	**627,168**	**130.9%**	**Gross Margin**	**7,789,911**	**4,661,814**	**3,128,097**	**67.1%**
				Administrative Expenses				
150,690	148,299	(2,391)	(1.6%)	Salaries, wages & employee benefits	1,706,386	1,719,503	13,117	0.8%
123	153	30	19.4%	Professional fees	1,876	1,836	(40)	(2.2%)
115,774	18,971	(96,803)	(510.3%)	Purchased services	216,989	227,652	10,663	4.7%
21,360	10,537	(10,823)	(102.7%)	Printing and postage	122,707	126,400	3,693	2.9%
2,084	2,116	32	1.5%	Depreciation & amortization	25,004	25,392	388	1.5%
33,679	4,155	(29,524)	(710.6%)	Other operating expenses	76,659	49,649	(27,010)	(54.4%)
7,255	4,414	(2,841)	(64.4%)	Indirect Cost Allocation, Occupancy Expense	54,446	49,561	(4,885)	(9.9%)
330,965	**188,645**	**(142,320)**	**(75.4%)**	**Total Administrative Expenses**	**2,204,067**	**2,199,993**	**(4,074)**	**(0.2%)**
				Operating Tax				
5,802	-	5,802	0.0%	Tax Revenue	35,349	-	35,349	0.0%
5,802	-	(5,802)	0.0%	Premium Tax Expense	35,349	-	(35,349)	0.0%
-	**-**	**-**	**0.0%**	**Total Net Operating Tax**	**-**	**-**	**-**	**0.0%**
775,444	**290,596**	**484,848**	**166.8%**	**Change in Net Assets**	**5,585,845**	**2,461,821**	**3,124,024**	**126.9%**
69.4%	***85.6%***	***16.2%***	***18.9%***	***Medical Loss Ratio***	***79.2%***	***86.9%***	***7.7%***	***8.9%***
9.2%	***5.7%***	***(3.5%)***	***(61.5%)***	***Admin Loss Ratio***	***5.9%***	***6.2%***	***0.3%***	***4.5%***

Preliminary

CalOptima
Building 505 - City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2020

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
-	-	-	0.0%	Rental Income	-	-	-	0.0%
-	**-**	**-**	**0.0%**	**Total Operating Revenue**	**-**	**-**	**-**	**0.0%**
				Administrative Expenses				
49,702	23,102	(26,600)	(115.1%)	Purchase services	574,868	277,214	(297,654)	(107.4%)
171,032	174,725	3,693	2.1%	Depreciation & amortization	2,018,851	2,096,700	77,849	3.7%
18,423	15,866	(2,557)	(16.1%)	Insurance expense	212,557	190,392	(22,165)	(11.6%)
144,806	140,162	(4,644)	(3.3%)	Repair and maintenance	1,224,181	1,681,944	457,763	27.2%
38,177	46,432	8,255	17.8%	Other Operating Expense	477,314	557,184	79,870	14.3%
(422,139)	(400,287)	21,852	5.5%	Indirect allocation, Occupancy	(4,507,770)	(4,803,434)	(295,664)	(6.2%)
(0)	**-**	**0**	**0.0%**	**Total Administrative Expenses**	**-**	**-**	**-**	**0.0%**
0	**-**	**0**	**0.0%**	**Change in Net Assets**	**-**	**-**	**-**	**0.0%**

OTHER INCOME STATEMENTS – JUNE MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.7 million, favorable to budget $0.9 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is $0.8 million, favorable to budget $0.5 million

CalOptima
Balance Sheet
June 30, 2020

ASSETS		LIABILITIES & NET POSITION	
Current Assets		Current Liabilities	
Operating Cash	$513,517,584	Accounts Payable	$74,656,446
Investments	589,466,103	Medical Claims liability	917,152,020
Capitation receivable	403,300,444	Accrued Payroll Liabilities	13,621,878
Receivables - Other	43,069,581	Deferred Revenue	23,423,696
Prepaid expenses	6,699,209	Deferred Lease Obligations	160,858
		Capitation and Withholds	142,981,028
Total Current Assets	**1,556,052,921**	**Total Current Liabilities**	**1,171,995,925**
Capital Assets			
Furniture & Equipment	39,890,502		
Building/Leasehold Improvements	8,437,734		
505 City Parkway West	51,620,226		
	99,948,461		
Less: accumulated depreciation	(53,293,891)		
Capital assets, net	46,654,570	Other (than pensions) post	
		employment benefits liability	26,172,858
Other Assets		Net Pension Liabilities	27,122,873
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	57,198,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,225,291,657**
Cash and Cash Equivalents	4,727,620		
Long-term Investments	580,156,273	Deferred Inflows	
Total Board-designated Assets	584,883,893	Excess Earnings	506,547
		Change in Assumptions	3,728,725
Total Other Assets	642,382,806	OPEB Changes in Assumptions	2,503,000
		Net Position	
TOTAL ASSETS	**2,245,090,297**	TNE	100,573,921
		Funds in Excess of TNE	923,430,517
Deferred Outflows		**TOTAL NET POSITION**	1,024,004,439
Contributions	1,047,297		
Difference in Experience	4,280,308		
Excess Earning	-		
Changes in Assumptions	5,060,465		
Pension Contributions	556,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,256,034,367**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,256,034,367**

Preliminary

CalOptima
Board Designated Reserve and TNE Analysis
as of June 30, 2020

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	160,116,170				
	Tier 1 - MetLife	158,842,359				
	Tier 1 - Wells Capital	159,246,689				
Board-designated Reserve		478,205,218	317,952,800	497,321,395	160,252,418	(19,116,177)
TNE Requirement	Tier 2 - MetLife	106,678,675	100,573,921	100,573,921	6,104,754	6,104,754
	Consolidated:	**584,883,893**	**418,526,722**	**597,895,316**	**166,357,172**	**(13,011,423)**
	Current reserve level	*1.96*	*1.40*	*2.00*		

CalOptima
Statement of Cash Flows
June 30, 2020

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	29,278,294	88,461,569
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	497,539	6,208,308
Changes in assets and liabilities:		
Prepaid expenses and other	582,557	(911,467)
Catastrophic reserves		
Capitation receivable	4,632,099	(94,428,258)
Medical claims liability	129,208,512	164,841,068
Deferred revenue	(92,940,037)	(27,611,067)
Payable to health networks	3,105,897	34,077,888
Accounts payable	10,863,353	31,989,720
Accrued payroll	4,442,420	7,603,072
Other accrued liabilities	(2,723)	116,346
Net cash provided by/(used in) operating activities	89,667,910	210,347,178
GASB 68 CalPERS Adjustments	(522,184)	(522,184)
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES:		
Net Asset transfer from Foundation	-	-
Net cash provided by (used in) in capital and related financing activities	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(3,144,359)	(15,759,806)
Change in Property and Equipment	(111,117)	(6,237,989)
Change in Board designated reserves	(1,740,493)	(24,738,486)
Change in Homeless Health Reserve	1,000,000	2,801,087
Net cash provided by/(used in) investing activities	(3,995,968)	(43,935,194)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	85,149,758	165,889,800
CASH AND CASH EQUIVALENTS, beginning of period	$428,367,826	347,627,784
CASH AND CASH EQUIVALENTS, end of period	**513,517,584**	**513,517,584**

BALANCE SHEET – JUNE MONTH:

ASSETS of $2.3 billion increased $83.3 million from May or 3.8%

- Operating Cash increased $85.1 million due to decrease in claims paid, HCC reconciliation, and timing of cash receipt and disbursements
- Receivables – Other increased $4.5 million due to increase in estimated Part D receivable from CMS
- Investments increased $3.1 million
- Capitation Receivables decreased $9.2 million due to timing of capitation received

LIABILITIES of $1.2 billion increased $54.7 million from May or 4.7%

- Claims Liabilities increased $129.2 million due to GME and CCI risk corridor
- Accounts Payable increased $10.9 million due to the payment timing of sales tax
- Capitation and Withhold increased $3.1 million
- Net Pension Liabilities increased $3.6 million due to the annual true-up to the CalPERS actuarial report
- Deferred Revenue decreased $92.9 million due to Proposition 56 and IGT 9

NET ASSETS total $1.0 billion

Homeless Health Initiative and Allocated Funds
as of June 30, 2020

		Amount
Program Commitment		$100,000,000
Funds Allocation, approved initiatives:		
Be Well OC	$11,400,000	
Recuperative Care	8,250,000	
Medical Respite	250,000	
Housing Supportive Services	2,500,000	
Clinical Field Team Start-Up & Federal Qualified Health Center (FQHC)	1,600,000	
Homeless Response Team (CalOptima)	6,000,000	
Homeless Coordination at Hospitals	10,000,000	
CalOptima Day & QI Program	1,231,087	
FQHC Mobile Unit Claims	300,000	
FQHC Mobile Unit Staff	270,000	
HCAP - Expansion	1,000,000	
Funds Allocation Total		42,801,087
Program Commitment Balance, available for new initiatives:		$57,198,913

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories. This report only lists Board approved projects.

Budget Allocation Changes
Reporting Changes as of June 2020

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS Application Development - Maintenance HW/SW (CalOptima Link Software)	IS Application Development - Maintenance HW/SW (Human Resources Corporate Application)	$32,700	Repurpose $32,700 from Maintenance HW/SW (CalOptima Link Software) to Maintenance HW/SW (Human Resources Corporate Application)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (Server 2016 Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$38,300	Reallocate $38,300 from Capital Project (Server 2016 Upgrade) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
July	Medi-Cal	IS Infrastructure - Capital Project (LAN Switch Upgrade)	IS Infrastructure - Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	$25,700	Reallocate $25,700 from Capital Project (LAN Switch Upgrades) to Capital Projects (505 IDF Upgrade and MDF Switch Upgrade)	2020
December	Medi-Cal	IS Infrastructure - Maintenance HW/SW - Microsoft True-Up	IS Infrastructure - Maintenance HW/SW - Network Connectivity - Extreme Networks	$53,000	Repurpose $53,000 from Microsoft True-Up to Network Connectivity - Extreme Networks.	2020
December	Medi-Cal	Facilities - 6th Floor Lunchroom Remodel	Facilities - Replace Conference Room AV Equipment	$13,000	To reallocate $13,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	2020
December	Medi-Cal	Facilities - Conference Room 910 Upgrades	Facilities - Replace Conference Room AV Equipment	$17,000	To reallocate $17,000 from Capital Projects 6th Floor Lunchroom Remodel and Conference Room 910 Upgrades to Capital Project Replace Conference Room AV Equipment.	2020
January	Medi-Cal	Member Survey - CG CAHPS	Inovalon Contract for HEDIS Software Training and Support hours	$40,000	To reallocate funds from Member Survey - CG CAHPS to Inovalon Contract for HEDIS Software Training and Support hours.	2020
May	PACE	PACE Administrative - HW/SW Maint..., Travel & Training, Membership, Food Svs/Supplies	PACE Center Support - Repair & Maint...	$27,500	To reallocate budget from PACE Administrative accounts to PACE Center Support to cover maintenance charges	2020
June	Medi-Cal	Health Ed & Disease Mgmt. - Incentives (Provider Incentives)	Health Ed & Disease Mgmt. - Incentives (Member Incentives)	$40,000	To repurpose funds from Provider Incentives to Member Incentives to provide additional funding needed for member incentives.	2020

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
August 6, 2020

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

- Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (OneCare and OneCare Connect):

  On January 10, 2020, CMS informed CalOptima that its OneCare and OneCare Connect programs have been selected to participate in the Calendar Year (CY) 2018 Medicare Part D Prescription Drug Event Validation (PEPV) audit.

  CMS conducts the audit to validate the accuracy of prescription drug event (PDE) data submitted by Medicare Part D sponsors for CY 2018 payments. CMS released the contract-specific documentation for both programs on January 24, 2020. CalOptima submitted supporting documentation for this audit on February 20, 2020. On February 25, 2020, CMS provided preliminary findings that the documentation has been accepted. No additional submissions are required at this time. CalOptima is awaiting CMS to provide the final findings report.

  On April 2, 2020, in light of the current public health crisis, CMS directed plans to cease making requests for documentation from providers regarding the CY 2018 PEPV audit. CMS will make an announcement when audit activities resume.

- CY2015 Medicare Part C Contract-level Risk Adjustment Data Validation (CON15 RADV) Audit:

  On November 21, 2019, CMS notified CalOptima that its OneCare program was selected to participate in the CY 2015 RADV audit. On January 10, 2020, CMS released the enrollee list and opened the submission window. CMS selected a total of thirty-three (33) members for this audit and requested the submission of medical record documentation by July 10, 2020.

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On March 30, 2020, in light of the current public health crisis, CMS suspended CY 2015 RADV audit activities and directed plans to cease making requests for documentation from providers immediately. CMS will make an announcement when audit activities resume. In the meantime, CMS will continue to review and provide feedback on medical records already submitted to CMS.

- Medicare Data Validation Audit (applicable to OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to conduct a Medicare Data Validation (MDV) audit of all Medicare Parts C and D data reported for the prior calendar year. A kick-off call with CalOptima's independent auditor, Advent, was held on January 6, 2020. Historically, the data validation audit season takes place from March through June each year. The audit includes a webinar validation and source documentation review of Medicare Parts C and D reporting data submitted for the prior calendar year.

  On April 22, 2020, CalOptima participated in the 2020 Medicare Parts C and D Data Validation Audit, conducted by CMS' contractor, Advent Advisory Group ("Advent"). The following reporting measures were reviewed:

  - Part C Special Needs Plans (SNPs) Care Management
  - Part D Medication Therapy Management (MTM) Programs

  On May 19, 2020, CalOptima submitted the requested documents for the sample selections for each of the required reporting measures. On June 26, 2020, Advent informed CalOptima that it received a final score of 100% for the audit for both its OneCare and OneCare Connect programs.

- CMS Program Audit Readiness (OneCare and OneCare Connect):

  On June 18 and June 19, 2020, CMS finalized the 2020 Program Audit Protocols for Medicare-Medicaid Plans (MMPs) and the Medicare Parts C and D Audit Protocols, respectively. Although CMS initially suspended various audit activities, including its program audits, CMS is now considering options for modifying the timing and scope of the program audits in order to complete them later this year. As such, CalOptima may receive an audit engagement letter from CMS for its OneCare and OneCare Connect programs sometime during the remainder of CY 2020 based on these audit protocols.

- Compliance Program Effectiveness (CPE) Audit (OneCare and OneCare Connect):
  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 administering the elements of an effective compliance program, as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The audit is expected to start in early August and continue through October 2020.

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.

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2. OneCare Connect

- National 2018 Risk Adjustment Data Validation (RADV) Audit:

  On January 13, 2020, CMS informed CalOptima that its OneCare Connect program has been selected to participate in the CY 2018 Medicare Part C Improper Payment Measurement, known as the National Risk Adjustment Data Validation (RADV) audit. CMS will be conducting medical record reviews to validate the accuracy of the CY 2018 Medicare Part C risk adjustment data. The results of this review will be used to calculate a program-wide improper payment rate for Medicare Part C. On February 14, 2020, the CMS submission window opened and CalOptima was notified that only one (1) enrollee with three (3) hierarchical condition categories (HCCs) was selected for validation. On March 23, 2020, CalOptima submitted medical records for all three (3) HCCs, in advance of the regulatory deadline of June 8, 2020.

  On April 13, 2020, CMS provided preliminary results, which indicated that the sampled HCCs were found within the medical records submitted and that no further action is required from CalOptima at this time. CalOptima is waiting for the final findings report.

3. Medi-Cal

- 2020 DHCS Medical Audit (Medi-Cal and OneCare Connect):

  The Department of Health Care Services' (DHCS) onsite audit of CalOptima took place from January 27, 2020 to February 7, 2020. The audit covered the review period of February 1, 2019 to January 31, 2020 and pertained to CalOptima's Medi-Cal program as well as elements of its OneCare Connect Medicaid-based services. DHCS reviewed an array of documents and data and conducted interviews with CalOptima staff as well as with a DHCS-selected delegate, Monarch HealthCare.

  On July 1, 2020, the DHCS provided its draft report which identified seven (7) findings in the audit areas of Access and Availability of Care and Member's Rights. The DHCS hosted an exit conference on July 7, 2020 to review the draft findings. Following the exit conference, CalOptima has fifteen (15) calendar days to dispute the content of the draft report, if necessary. The DHCS is expected to finalize its report and request a Corrective Action Plan (CAP) from CalOptima by July 22, 2020. CalOptima will have thirty (30) calendar days from date of receipt, or no later than August 21, 2020, to respond to the CAP request.

B. Regulatory Notices of Non-Compliance

CalOptima did not receive any notices of non-compliance from its regulators for the month of May and June 2020.

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.

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C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Auditing: Customer Service (Medi-Cal)

CalOptima's Audit & Oversight department performed an internal audit of CalOptima's Customer Service department's process for handling inquiries and exempt grievances for the Medi-Cal program for the review period of October 1, 2019 through December 31, 2019. The audit areas included call log classification and exempt grievances.

- Medi-Cal Customer Service: Inquiries (Call Logs)

Month(s)	Misclassified Calls	File Review	Universe Review
October – December 2019	88.89%	87.50%	100%

- For the October-December 2019 file review of Medi-Cal inquiries, CalOptima's Customer Service department received an overall compliance score of 92.13% for a focused review of nine (9) inquiries. The file review consisted of, but is not limited to, classification of inquiries, HIPAA verification, complete call documentation, and timely exempt grievance resolution.

- Based on a focused review of nine (9) inquiries, the lower compliance score of 88.89% for the misclassified calls was due to one (1) misclassified call within the files selected.

- Based on a focused review of eight (8) inquiries, the lower compliance score of 87.50% was due to incorrect call documentation.

- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of inquiries. The A&O department continues to work with the Customer Service department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate classification of call inquiries.

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.

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- Medi-Cal Customer Service: Exempt Grievances

Month(s)	Log Requirements	Universe Accuracy	Classification of Exempt Grievances	Accurate Documentation of Exempt Grievances	Complete Resolution of Exempt Grievances	Resolution Timeliness
October – December 2019	100%	100%	100%	100%	100%	100%

➢ For the October-December 2019 file review of Medi-Cal exempt grievances, CalOptima's Customer Service department received a compliance score of 100% based on the overall universe of exempt grievances and a focused review of nine (9) exempt grievances selected for review.

2. Internal Auditing: Behavioral Health Integration Post-Implementation Assessment (OneCare and OneCare Connect)

CalOptima's Audit & Oversight (Internal) department performed a post-implementation assessment of internal processes for the OneCare and OneCare Connect behavioral health transition. The assessment was comprised of a desktop review of all policies, procedures, workflows, and file reviews, as applicable. Below are the assessment areas and audit scores:

Assessment Areas	Scores
Claims	96.7%
Contracting	100%
Credentialing	100%
Customer Service	100%
Cultural & Linguistics	100%
Provider Relations	100%
Quality Improvement	100%
Regulatory Affairs & Compliance (Medicare)	100%
Utilization Management	100%

➢ For the claims assessment, the lower compliance score of 96.7% was due to missing documentation.

➢ CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of claims policies. The A&O department continues to work with the Claims department to

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.

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remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate policies.

3. Internal Auditing: PACE

CalOptima's Audit & Oversight department conducted a full-scope audit of CalOptima's PACE during the first quarter of 2020. The core operational areas were reviewed for compliance with universe, timeliness, and clinical decision-making requirements. The audit areas included:

- After Hour Calls
- Appeals
- Grievances
- List of Personnel
- Participant Medical Records
- Quality Assessment Initiatives
- Service Delivery Requests

- PACE After Hour Calls:

Month(s)	Universe Integrity
April – September 2019	100%

- For the April-September 2019 file review of after hour calls, CalOptima's PACE department received a compliance score of 100% for universe review.

- PACE Appeals:

Month(s)	Universe Integrity	Classification Score	Acknowledgement Letter	Language Preference	Member Notice Content	Resolution of Appeal
April – September 2019	0%	100%	66.67%	66.67%	0%	100%

- For the April-September 2019 file review of appeals, CalOptima's PACE department received an overall compliance score of 55.56% for a focused review of five (5) appeals.

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- The lower compliance score of 0% for universe integrity was due to incorrect data in the universe.
- PACE received a lower compliance score of 66.67% for untimely acknowledgement letters.
- The lower compliance score of 66.67% for language preference was due to notices not issued in the member's preferred language.
- The lower compliance score of 0% for member notice content was due to inaccurate member notices.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of appeals. The A&O department continues to work with the PACE department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate and timely appeals.

- PACE Grievances:

Month(s)	Universe Integrity	Classification Score	Grievance Acknowledged ≤ 5 Calendar Days of Receipt	Language Preference	Participant Notice Content	Resolution of Grievances Resolved ≤ 30 Calendar Days of Receipt
April – September 2019	100%	100%	100%	50%	0%	100%

- For the April-September 2019 file review of grievances, CalOptima's PACE department received an overall compliance score of 75% for a focused review of ten (10) grievances.
- The lower compliance score of 50% for language preference was due to multiple notices not issued in the member's preferred language.
- The lower compliance score of 0% for participant notice content was due to multiple inaccurate member notices.
- CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of grievances. The A&O department continues to work with the PACE department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate grievances.

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.

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- PACE Personnel Records:

Month(s)	Universe Integrity	Licensure	OIG Exclusions	Background Checks	Up-to-Date Records for Communicable Diseases and Immunizations	Personnel Training
April – September 2019	100%	100%	100%	100%	80%	100%

  - For the April-September 2019 file review of personnel records, CalOptima's PACE department received a compliance score of 96.67% for a focused review of ten (10) records.
  - The lower compliance score of 80% was due to two (2) untimely immunizations.
  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of PACE's personnel records. The A&O department continues to work with the PACE department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate personnel records.

- PACE Participant Medical Records:

Month(s)	Universe Integrity	Adequate Care	Interdisciplinary Team (IDT) Participation	Assessments	Medical Record Accuracy	Care Plan Development
April – September 2019	90%	100%	100%	100%	100%	100%

  - For the April-September 2019 file review of PACE participant medical records, CalOptima's PACE department received an overall compliance score of 98.33% for a focused review of ten (10) records.
  - The lower compliance score of 90% for universe integrity was due to a misclassified file.
  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of participant medical records. The A&O department continues to work with the PACE department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate participant medical records.

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.

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- PACE Quality Assessment Initiatives:

Month(s)	Universe Integrity
April – September 2019	100%

  - For the April-September 2019 file review of PACE quality assessment initiatives, CalOptima's PACE department received a compliance score of 100% for universe review. Per CMS audit protocols, a quality initiative is a set of data used to measure and identify areas of good or problematic performance within a PACE organization.

- PACE Service Delivery Requests (SDRs):

Month(s)	Universe Integrity	SDR Denials	SDR Approvals
April – September 2019	0%	9.09%	80%

  - For the April-September 2019 file review of PACE SDRs, CalOptima's PACE department received a compliance score of 29.69% for a focused review of sixteen (16) SDRs.
  - The lower compliance score of 0% for universe integrity was due to incorrect data in the universe.
  - The lower compliance score of 9.09% for SDR denials was due to multiple documents without appropriate appeals rights given.
  - The lower compliance score of 80% for SDR approvals was due to universe integrity issues.
  - CalOptima's Audit & Oversight (A&O) department issued a request for a corrective action plan (CAP) for deficiencies identified during the focused review of SDRs. The A&O department continues to work with the PACE department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure accurate SDRs.

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.

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4. Health Network Monitoring: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timely Urgent Requests	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified	Letter Score for Modified	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2020	81%	83%	91%	85%	85%	90%	88%	71%	73%	80%	93%	86%	76%
March 2020	62%	84%	89%	95%	95%	93%	98%	100%	67%	84%	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	89%	78%	95%	80%	90%	89%	94%	84%	69%	80%	Nothing to Report	Nothing to Report	Nothing to Report

- Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended file reviews of UM Medi-Cal files for the months of March 2020 and April 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for monthly monitoring.

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. Of the forty (40) files received from the two (2) health networks, six (6) files were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for decision (Routine – 5 Business Days)
  - Failure to meet timeframe for provider initial notification (24 hours)

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for clinical decision making (CDM). Of the thirty-six (36) files received from the two (2) health networks, thirteen (13) files were deficient. Deficiencies for the lower scores for CDM include the following:
  - Failure to have appropriate professional make decision
  - Failure to obtain adequate clinical information
  - Failure to cite criteria for decision

- Based on a focused review of select files, two (2) health networks drove the lower compliance letter score. Of the forty (40) files received from the two (2) health networks, fifteen (15) files were deficient. Deficiencies for the lower letter scores include the following:
  - Failure to describe why the request did not meet criteria in lay language

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.

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- 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 or modify

➢ Based on the overall universe of Medi-Cal authorizations for February 2020, CalOptima's health networks received an aggregate compliance score of 99.91% for timely processing of routine authorization requests and a compliance score of 99.06% for timely processing of expedited authorization requests.

➢ CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of prior authorization requests The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2020	100%	93%	98%	92%
March 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

➢ Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended the file review of Medi-Cal claims for the months of March 2020 and April 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic.

➢ Based on the overall universe of Medi-Cal claims for February 2020, CalOptima's health networks received an overall compliance score of 92.68% for timely processing of claims.

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.

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- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

5. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management: Prior Authorization Requests

Month	Timeliness for Expedited Initial Organization Determinations (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determinations (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
February 2020	88%	100%	79%	100%	96%	100%	96%	96%
March 2020	100%	N/A	100%	100%	95%	100%	84%	98%
April 2020	70%	N/A	99%	95%	99%	Nothing to Report	Nothing to Report	Nothing to Report

- Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended the file review of prior authorization requests for the months of March 2020 and April 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for monthly monitoring.

- Based on a focused review of select files, two (2) health networks drove the lower compliance score for timeliness. Of the thirty (30) files received from the two (2) health networks, seven (7) files were deficient. Deficiencies for the lower scores for timeliness include the following:
  - Failure to meet timeframe for member oral notification (expedited)
  - Failure to meet timeframe for member written notification (expedited)

- Based on a focused review of select files, one (1) health network drove the lower compliance letter score. Of the ten (10) files received from one (1) health network, one (1) file was deficient. Deficiencies for the lower letter scores include the following:
  - Failure to provide letter with description of services in lay language

- Based on the overall universe of OneCare authorization requests for CalOptima's health networks for February 2020, CalOptima's health networks received an overall

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.

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compliance score of 84.51% for timely processing of standard Part C authorization requests and 68.33% for timely processing of expedited Part C authorization requests.

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2020	94%	94%	100%	96%
March 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended the file review of Medi-Cal claims for the months of March 2020 and April 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic.

- Based on the overall universe of OneCare claims for CalOptima's health networks for February 2020, CalOptima's health networks received the following overall compliance scores for timely processing of claims:
  - 71% for non-contracted clean claims paid or denied within 30 calendar days of receipt
  - 85% for contracted clean and unclean and non-contracted unclean claims paid or denied within 60 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the focused review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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.

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6. Health Network Monitoring: 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
February 2020	96%	100%	91%	97%	94%	98%	77%	96%	50%	50%	50%
March 2020	100%	67%	94%	100%	93%	88%	46%	57%	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	100%	N/A	97%	100%	100%	67%	100%	93%	75%	75%	89%

- Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended the file review of OneCare Connect prior authorization requests for the months of March 2020 and April 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic. Health networks under sanction were not exempt and continued to provide files for monthly monitoring.
  - Based on a focused review of select files, one (1) health network drove the lower compliance score for timeliness. Of the three (3) files received from the health network, one (1) file was deficient. The deficiency for the lower score for timeliness is for the network's failure to meet the timeframe for provider initial notification (24 hours).
- Based on the overall universe of OneCare Connect authorization requests for CalOptima's health networks for February 2020, CalOptima's health networks received an overall compliance score of 99.90% for timely processing of routine authorization requests and 99.80% for timely processing of expedited authorization requests.
- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of prior authorization requests. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of authorizations within regulatory requirements.

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.

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- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2020	97%	93%	99%	95%
March 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2020	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Audit & Oversight (External), with approval from the Audit & Oversight Committee and Compliance Committee, suspended the file review of OneCare Connect claims for the months of March 2020 and April 2020, to allow delegates to focus their efforts and resources to serve the arising needs and ensure the safety of CalOptima members, providers and the general community as a result of the COVID – 19 pandemic.

- Based on the overall universe of OneCare Connect claims for CalOptima's health networks for February 2020, CalOptima's health networks received the following overall compliance scores:
  - 95.02% for non-contracted and contracted clean claims paid or denied within 30 calendar days of receipt
  - 93.22% for non-contracted and contracted unclean claims paid or denied within 45 calendar days of receipt
  - 99.93% for non-contracted and contracted clean claims paid or denied within 90 calendar days of receipt

- CalOptima's Audit & Oversight (A&O) department issued requests for corrective action plans (CAPs) to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The A&O department continues to work with each health network to remediate the deficiencies by identifying accurate root causes and implementing quality controls such as but may not be limited to --- staff training, process development, system enhancements, ongoing inline monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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.

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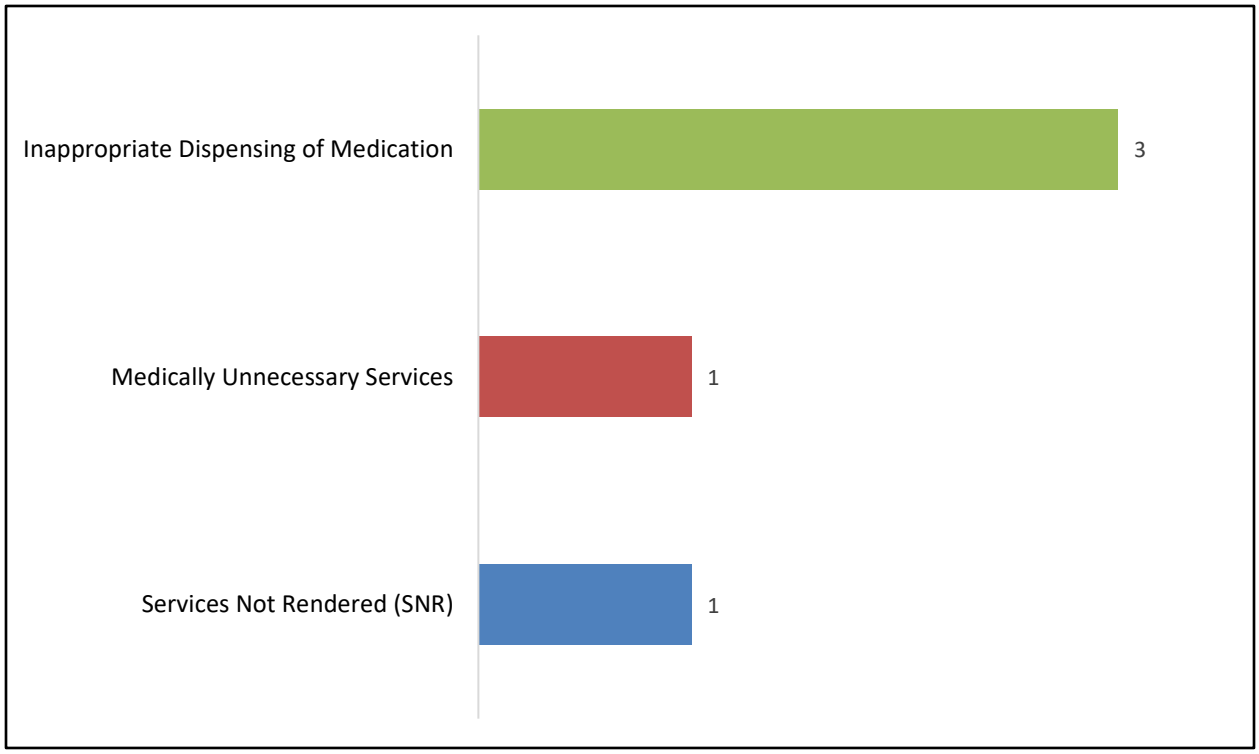
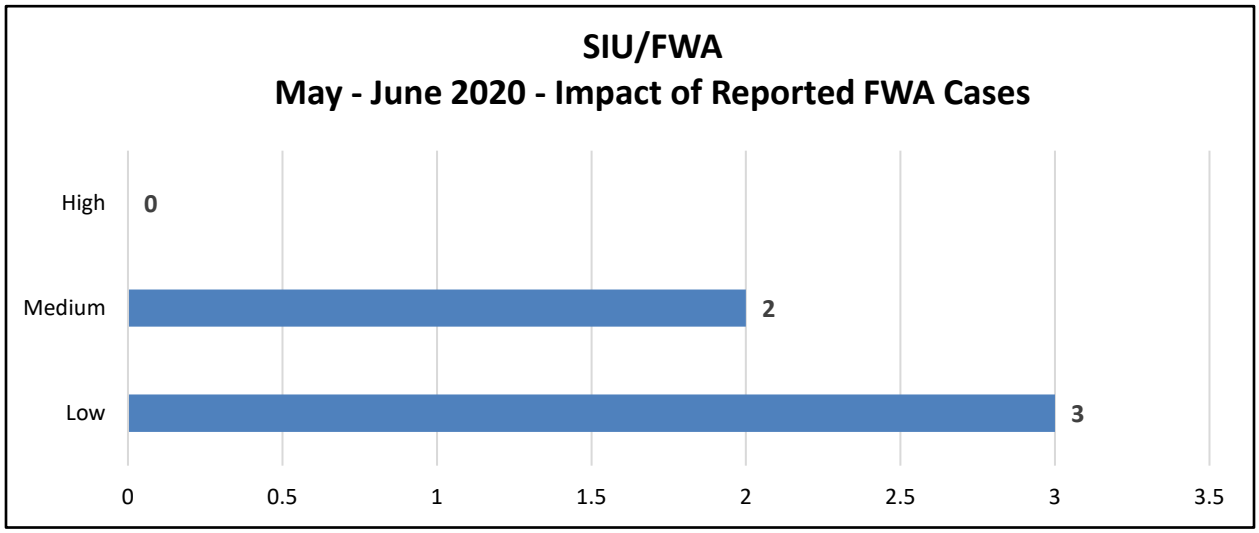
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in May and June 2020)





Total Number of Referrals Reported to DHCS (State)	5
Total Number of Referrals / Fraud Cases Reported to DHCS and MEDIC	0
Total Number of Referrals Reported	**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.

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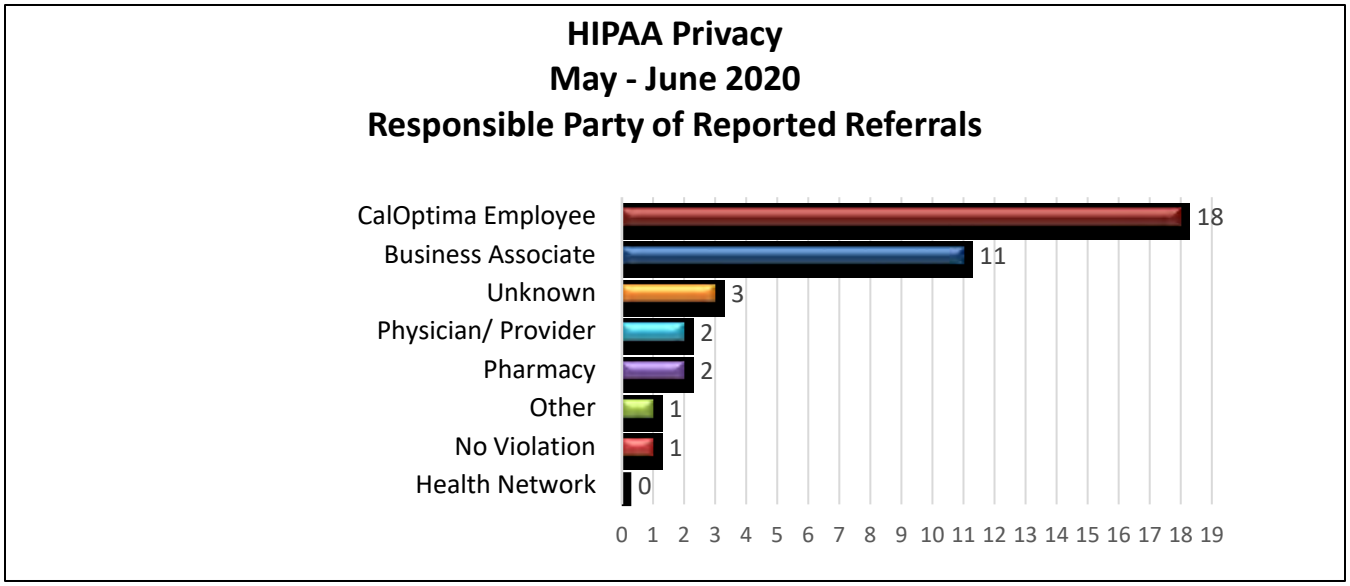
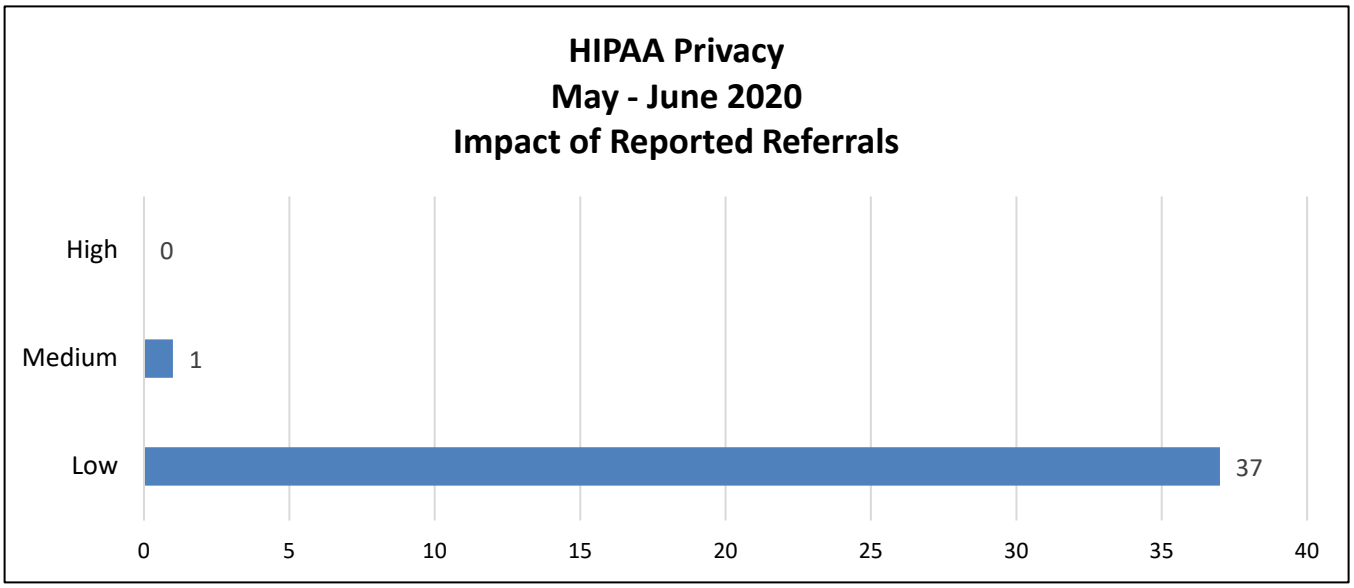
E. Privacy Update: (May and June 2020)





Total Number of Referrals Reported to DHCS (State)	38
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**38**

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.

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

July 10, 2020

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: July Board of Directors Report

The United States passed another grim milestone in its novel coronavirus (COVID-19) outbreak: 3 million confirmed cases. While the Trump Administration is focused on reopening the economy, the recent surge in new U.S. cases across much of the South and West, including southern California, is putting pressure on Congress to pass additional economic relief legislation. Meanwhile, appropriations work continues apace in the House even as the Senate remains deadlocked. This report covers legislative developments through July 9, 2020.

COVID-19 Relief Legislation

Treasury Secretary Steven Mnuchin met with Senate Republicans before the July 4 recess to discuss next steps on a possible "Phase 4" COVID-19 relief package. Senate Majority Leader Mitch McConnell (R-KY) has suggested that Republicans will assess the state of the economy this month and could release draft legislation after returning to Washington on July 20. Senate Democrats have asked to negotiate on a bipartisan basis, but it appears likely that Republicans will proceed initially without Democratic input. Important issues for Phase 4 negotiations include extension of enhanced unemployment benefits, additional relief for state and local governments, liability protections for schools and businesses operating during the pandemic, as well as additional funding for health care providers, schools, and low-income populations.

Leader McConnell suggested the next round of individual assistance will be targeted to a lower-income group, and stated that liability protections for businesses and schools that reopen would be retroactive to December 2019 and extend through 2024. Once the House and Senate return from the two week Fourth of July recess on July 20, there will be a narrow window to reach bipartisan agreement on a Phase 4 package before the August recess, which in the Senate is set to begin on August 7. The negotiations on this COVID relief package – most likely the last before the November election – will be more contentious than the previous packages.

FY 2021 Appropriations

Although ongoing COVID-19 business in the House delayed the chamber's initial plans to pass all 12 of its appropriations bills in June, the House Appropriations Committee is pursuing an

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aggressive schedule to complete Subcommittee and Full Committee mark-ups by mid-July, with floor votes expected the weeks of July 20 and 27.

The House Appropriations Committee released a draft of its Labor-Health and Human Services (HHS) spending bill ahead of a Subcommittee mark-up on July 7, which included significant increases in funding for HHS agencies and additional emergency spending to address the COVID-19 crisis and to prepare for future public health emergencies. The bill was advanced by the Subcommittee on a party-line vote, with Republicans objecting to the emergency funding in the measure.

The Senate Appropriations Committee planned to mark up seven appropriations bills before the July recess, but partisan conflicts over funding levels and policy priorities, including COVID-19 aid and policing reform, brought negotiations to a standstill. Leader McConnell reportedly has told senators to expect a year-end Continuing Resolution (CR) or omnibus bill to resolve FY 2021 spending decisions.

ACA Enhancement Bill

On June 29, the House voted 234-179 to pass the "Patient Protection and Affordable Care Enhancement Act" (H.R. 1425). The bill passed largely along party lines and is opposed by the GOP-controlled Senate's leadership. Among other provisions, H.R. 1425 would: expand premium tax credits under the ACA; strengthen incentives for states to expand Medicaid; allow the HHS Secretary to reduce the Federal Medical Assistance Percentages (FMAP) rate for non-expansion states; and reverse the Trump Administration's expansion of short-term, limited-duration insurance. The package also includes the drug price negotiation provisions of the House-passed "Elijah E. Cummings Lower Drug Costs Now Act" (H.R. 3).

Infrastructure Package

The House on July 1 voted 233-188 along party lines to pass a $1.5 trillion infrastructure package (H.R. 2) that includes a number of heath care provisions. The "Moving Forward Act" includes re-establishment of the Hill-Burton program, which provides funding for the construction and modernization of hospitals and medical facilities. Specifically, the bill authorizes a total of $10 billion in grants for Fiscal Years 2021-2025. The program would prioritize awards for projects that include modernization for public health preparedness or cybersecurity. Entities that receive funds under the program would be required to ensure they will use iron and steel products produced in the United States and ensure the project will increase energy efficiency, energy resiliency, or a greater use of renewable energy. H.R. 2 also includes provisions related to community health center capital project grants; pilot program funding for

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laboratory infrastructure; and grants to improve infrastructure at teaching health centers and behavioral health centers.

Senate Republicans have expressed opposition to H.R. 2, but Senate Committees are working behind the scenes on their own infrastructure proposals. A package could come together before year-end, but likely not before the August recess.

Committee Activity

Congressional committees continue to hold numerous hearings on the COVID-19 pandemic and the Administration's response to the outbreak. On June 17, the Senate Health, Education, Labor and Pensions (HELP) Committee held a hearing on telehealth and lessons learned during the pandemic. Members on both sides of the aisle expressed strong interest in making permanent at least some of the telehealth flexibilities that have been implemented in response to the pandemic. Other recent hearings have also focused on racial and ethnic health disparities among COVID-19 patients, the role of the Strategic National Stockpile (SNS) in pandemic response, nursing home safety, the impact on mental health, and the steps needed to reopen schools in the fall. On July 21, the House Energy and Commerce Committee's Subcommittee on Oversight & Investigations will hold a hearing on COVID-19 vaccine development. Executives from AstraZeneca, Johnson & Johnson, Merck, Moderna, and Pfizer will testify at the hearing.

Provider Relief Fund

HHS announced additional allocations from the Provider Relief Fund on June 9, including $15 billion for eligible providers that participate in state Medicaid and CHIP programs and have not received a payment from the Provider Relief Fund General Allocation, and $10 billion in Provider Relief Funds for safety-net hospitals. HHS launched an enhanced Provider Relief Fund Payment Portal that will allow eligible Medicaid and CHIP providers to report their annual patient revenue, which will be used as a factor in determining their Provider Relief Fund payments. Medicaid providers must submit their data to HHS by July 20, 2020, in order to receive payments. More than $102 billion has been allocated to various providers as of June 15, with further disbursements expected in the coming weeks and months.

On July 6, Rep. Bob Gibbs (R-OH) announced that he had secured nearly $2 billion in additional funding for Children's Hospitals, many of which serve a high percentage of Medicaid patients. Reports indicate that the next round of funding will seek to help providers who serve primarily Medicaid patients but are ineligible for the recent Medicaid distribution because they received a small payment from the General Distribution, which was based on Medicare rates.

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CalOptima Hill Outreach

Akin Gump facilitated CalOptima's participation in the ACAP virtual fly-in this month by securing and hosting virtual meetings with the entire Orange County House delegation for interim CEO Richard Sanchez. Meetings were held with Reps. Gil Cisneros (D-CA-39), Mike Levin (D-CA-49), Linda Sanchez (D-CA-38), Lou Correa (D-CA-46), Harley Rouda (D-CA-48), Alan Lowenthal (D-CA-47), and staff for Rep. Katie Porter (D-CA-45). We discussed CalOptima's support for the community in response to the COVID-19 outbreak and the importance of federal support, including increased FMAP funding provided by the HEROES Act.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

June 26, 2020

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

On Monday, Governor Newsom and legislative leadership announced that they had reached agreement on a state budget.

As you know, the Legislature adopted its own version of a budget last Monday to meet its constitutional deadline to do so by June 15. In adopting their "legislative budget," the Legislature rejected the Governor's proposed $14 billion in painful trigger cuts to social safety net programs and K-12 schools, which would have been implemented on July 1. Instead the Legislature adopted far fewer cuts, many of which would have been triggered on October 1, and relied more heavily on the state's reserves, payment deferrals, and internal borrowing.

For the first time in nine years, the Governor has had to give much more ground in the budget than legislative leadership. The "compromise" budget the Legislature is poised to pass generally aligns with the Legislature's proposal. The "cuts" in the compromise budget will now be implemented July 1, and stay in place unless triggered away if the state receives federal funding to backfill the budget by October 15.

The compromise budget, passed by the Senate last night and poised to pass out of the Assembly today, is a big risk to the Governor and the state's finances. In the short run, numerous constituencies of democrats will be happy with the preservation of social safety net programs. In the long run, very few of the budget solutions addressing the

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The bottom line is that the Governor and Legislature could be setting themselves up for tougher budgets in future years. This isn't unprecedented. During the Great Recession, Democratic leaders in the Legislature could not reach agreement on how to eliminate the state's structural deficit with then Governor Schwarzenegger and Republican minority leaders. Instead, the state adopted numerous budgets balanced on hopeful revenue projections, deferrals, internal borrowing, and budget gimmicks. The state's credit rating fell and a massive $34.7 billion "wall of debt" grew. Governor Brown spent much of his second stint in the Governor's Office addressing California's structural budget deficit and paying down the "wall of debt." In the end, he had to rely on harsh cuts coupled with new taxes to do so.

It is possible that when the Legislature returns from its summer recess on July 13 that there will be a push for new taxes to help prop up the state's finances. That is a risky proposition for moderate Democrats in an election year, though. Even if taxes aren't put on the table, the Legislature and Governor are expected to revisit the budget after the July 15 tax filing deadline. They will likely have to address various shortcomings in the compromise budget at that time.

COVID-19 and the Budget

Unfortunately, this week saw record high numbers of new COVID-19 cases in California. With infections and hospitalization on the rise, the Governor is once again facing a difficult situation when it comes to reopening the economy.

A provision of the budget compromise described above may help the Governor with this problem. Under the new provision, the Governor's Department of Finance (DOF) will be empowered to withhold a county's share of $2 billion of social safety net and COVID-19 relief funding if that county is not adhering to state and federal guidance and directives related to COVID-19. This includes the statewide order to wear masks and the guidance to businesses related to sanitation and social distancing.

The Governor continues to be savvy in his navigation of pandemic politics. On the one hand, he has issued guidance to counties and residents to follow in reopening while delegating decision making based on that guidance to local public health officials. He has now added some teeth to that guidance by making funding contingent upon compliance. This choice gives the Governor the moral high ground to say he has encouraged Counties to do the right thing and even punished them for not doing so. If Counties ultimately choose to ignore state guidance, the Governor will be able to say that he punished that behavior.

We expect work on the budget to continue on-and-off in the coming months. We will keep you apprised of further developments.

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EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate

July 2, 2020

LEGISLATIVE UPDATE
Edelstein Gilbert Robson & Smith LLC

On March 19, California became the first state to issue a statewide shelter in place order. The shelter in place order proved to be an effective tool to slow the spread of COVID-19. In fact, California bent the curve so successfully that Governor Newsom confidently sent hundreds of ventilators to the east coast and began sharing masks with other states struggling to procure personal protective equipment.

While the Governor's efforts bent the curve, they also resulted in economic trauma as businesses across the state were forced to close their doors and lay off employees. In May, the state's unemployment rate hit 16.3% and the impact on the state's economy resulted in a massive $54 billion budget shortfall.

Facing political pressure and outright defiance from some Counties, Governor Newsom laid out a phased plan to allow Counties to reopen businesses. Over the next month and a half, the Governor modified guidelines and worked with Counties to allow a rapid reopening of the economy.

7,000 new cases of COVID-19 were reported Monday, and 6,000 more on Tuesday. Hospitalization rates are up more than 50%. Sacramento County is nearly out of ICU beds and Imperial County, a hot bed for new infections, is actively transferring new patients out of its overwhelmed healthcare system. Public health experts warn that the higher rates of infection statewide are largely attributable to social gatherings among family and friends. Nevertheless, the Governor has now directed 19 counties to close indoor operations at restaurants, wineries and tasting rooms, movie theaters, family entertainment centers, zoos and museums, and cardrooms.

It is difficult to predict exactly how the Governor and the Legislature will react to the resurgence of COVID-19. However, there are a number of political concerns they must weigh.

Reopening vs. Closing

As noted above, the Governor has already acted to close many businesses that had just been allowed to reopen. While he acknowledges that the increasing infection rate is being driven largely by social gatherings, taking a more conservative stance on reopening is not off the table as a means to alert Californians to the growing spread of the disease.

The Budget

California is reeling from one of the worst budget crises on record. Closing the economy could exacerbate that crisis. The recently enacted budget could add to those woes because it included fewer substantive cuts and left fewer reserves to reduce the

impact of the recession in the next budget year. The Legislature and the Governor are expected to revisit their recent budget agreement after the Legislature returns to session on July 13.

Legislative Priorities

While the Legislature committed to addressing "essential business" when it returned to session in early May, it has showed little discipline in taking bills off the table. To date, the Legislature has showed a willingness to continue operating despite the pandemic. Last week an Assembly staffer tested positive for COVID-19, and an Assemblymember self-quarantined after she was exposed to somebody infected with the virus. While it seems unlikely, if infection continues to increase, the Legislature may have to revisit both its schedules and its priorities for 2020.

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2019–20 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 266 McCollum	**Paycheck Protection Program and Health Care Enhancement Act:** Authorizes $483 billion to replenish segments of the CARES Act, expand coronavirus testing, and provide more support to hospitals and providers during this pandemic. Of the $483 billion, this bill includes: ■ $310 billion in funding for the Small Business Administration's PPP; ■ $10 billion for Economic Injury Disaster Loans; ■ $75 billion for the provider relief fund, managed by the Department of Health and Human Services, to cover treatment for COVID-19 patients and lost revenue from canceled elective procedures; and ■ $25 billion to research, develop, validate, manufacture, purchase, administer, and expand capacity for COVID-19 tests.	**04/24/2020** Signed into law **04/23/2020** Passed the House **04/21/2020** Passed the Senate **01/08/2019** Introduced	CalOptima: Watch
H.R. 748 Courtney	**CARES Act:** Authorizes $2.2 trillion in spending for health care and employment-related interventions. This includes: ■ $1.5 billion to support the purchase of personal protective equipment, lab testing, and other activities; ■ $127 billion to provide grants to hospitals, public entities, and nonprofits, and Medicare and Medicaid suppliers and providers to cover unreimbursed health care related expenses or lost revenues due to COVID-19; ■ $1.32 billion in supplemental funding for community health centers; ■ $955 million to support nutrition programs, home and community-based services, support for family caregivers, and expanded oversight for seniors and individuals with disabilities; ■ $945 million to support research on COVID-19; and ■ $425 million to increase mental health services.	**03/27/2020** Signed into law **03/27/2020** Passed the House **03/25/2020** Passed the Senate **01/24/2019** Introduced	CalOptima: Watch
H.R. 6201 Lowey	**Families First Coronavirus Response Act:** Allocates billions of federal funding support related to COVID-19. Funds are to be utilized for an emergency increase in the Federal Medical Assistance Percentages (FMAP) for Medicaid of 6.2%, emergency paid sick leave and unemployment insurance, COVID-19 testing at no cost, food aid and other provisions. Of note, on March 6, 2020, President Trump signed into law an emergency supplemental funding package of $8.3 billion for treating and preventing the spread of COVID-19.	**03/18/2020** Signed into law **03/17/2020** Passed the Senate **03/14/2020** Passed the House **03/11/2020** Introduced	CalOptima: Watch
H.R. 6462 Cisneros, Gallegos	**Emergency Medicaid for Coronavirus Treatment Act:** Would expand Medicaid eligibility to any American diagnosed with COVID-19 or any other illness that rises to the level of a presidential national emergency declaration. Additionally, would require Medicaid coverage for all COVID-19 treatment and testing to continue even after the national emergency is over.	**04/07/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 6666 Rush	**COVID-19 Testing, Reaching, and Contacting Everyone (TRACE) Act:** Would authorize the Centers for Disease Control and Prevention (CDC) to award grants for testing, contact tracing, monitoring, and other activities to address COVID-19. Those eligible to receive grant funding would include federally qualified health centers, nonprofit organizations, and certain hospitals and schools. Additionally, would allocate $100 billion for fiscal year 2020 for the disbursement of CDC grant funds.	**05/01/2020** Introduced	CalOptima: Watch
AB 89 Ting	**Emergency Budget Response to COVID-19:** Similar to SB 89, would appropriate $500 million General Fund by amending the Budget Act of 2019. Funds are to be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, would authorize additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
AB 117 Ting	**Emergency Budget Response to COVID-19 at Schools:** Similar to SB 117, appropriate $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds would be distributed by the Superintendent of Public Instruction.	**03/16/2020** Amended and referred to the Senate Committee on Budget and Fiscal Review **12/03/2018** Introduced	CalOptima: Watch
SB 89 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19:** Similar to AB 89, appropriates $500 million General Fund by amending the Budget Act of 2019. Funds will be allocated to any use related to Governor Newsom's March 4, 2020 State of Emergency regarding COVID-19. Additionally, authorizes additional appropriations related to COVID-19 in increments of $50 million, effective 72 hours following notification of the Director of Finance. Of note, the total amount appropriated to COVID-19 is not to exceed $1 billion.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
SB 117 Committee on Budget and Fiscal Review	**Emergency Budget Response to COVID-19 at Schools:** Similar to AB 117, appropriates $100 million Proposition 98 General Fund to ensure schools are able to purchase protective equipment or supplies for cleaning school sites. Funds will be distributed by the Superintendent of Public Instruction.	**03/17/2020** Signed into law **03/16/2020** Enrolled with the Governor **01/10/2019** Introduced	CalOptima: Watch
SB 275 Pan, Leyva	**Personal Protective Equipment:** Would require the State Department of Public Health to establish a personal protective equipment (PPE) stockpile to ensure an adequate supply of PPE for health care workers and essential workers. Would require the stockpile to have enough supplies for no less than a 90-day pandemic or other health emergency. Additionally, would require providers, clinics, health facilities, and home health agencies to maintain a stockpile of PPE.	**06/17/2020** Referred to Committee on Business and Professions **05/02/2019** Passed Senate floor; Referred to Assembly floor **02/13/2019** Introduced	CalOptima: Watch

STATE BUDGET BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 79	**Human Services:** Enacts human services trailer bills in the California 2020-2021 budget. ■ Department of Developmental Services supplemental rate increases for specified providers including, independent living programs, infant development programs, and early start specialized therapeutic services ■ In-Home Supportive Services reassessment extensions due to delays related to COVID-19 and Governor Newsom's executive state of emergency order	**06/29/2020** Signed into law **06/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 80	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal managed care capitated payment rate reduction of 1.5 percent for the 18-month bridge period ■ Implementation of a Medi-Cal risk corridor for the 18-month bridge period ■ Prop 56 value-based payments and supplemental payments ■ Extension of the Medi-Cal 2020 Demonstration ■ 340B Supplemental Payment Pool for non-hospital clinics ■ Expansion of full-scope Medi-Cal to seniors, regardless of immigration status ■ Extension of coverage for COVID-19 to uninsured individuals ■ Health Care Payment Data Program ■ Reimbursement for medication-assisted treatment services	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 81	**Public Health:** Enacts health care trailer bills in the California 2020-2021 budget. ■ Medi-Cal rate reimbursement methodology adjustments for skilled nursing facilities during the COVID-19 pandemic ■ Implementation of the skilled nursing facility quality assurance fee ■ County access to Mental Health Services Act funds for additional support related to COVID-19	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 83	**Housing:** Enacts housing trailer bills in the California 2020-2021 budget. ■ Funding to continue Project Roomkey ■ Bypassing certain California Environmental Quality Act (CEQA) regulations related to Project Roomkey	**6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
AB 89	**Fiscal Year 2020-2021 California State Budget:** Enacts a $202.1 billion spending plan for Fiscal Year 2020-2021, with General Fund spending at $133.9 billion. The following included within the state budget will have a direct impact to Medi-Cal: ■ Funding to address Medi-Cal caseloads ■ Provisions to maintain Community Based Adult Services, the Multipurpose Senior Services Program, and other optional benefits ■ Funding to address the COVID-19 pandemic	**06/29/2020** Signed into law **6/26/2020** Passed Assembly floor **06/25/2020** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch

AFFORDABLE CARE ACT

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1425 Craig	**Patient Protection and Affordable Care Enhancement Act (PPACEA):** Would, among other things, lower health care costs through fair drug price negotiations, provide additional protections for those with preexisting health conditions, and offer 100 percent federal matching funds for states that choose to expand Medicaid under the Affordable Care Act. The bill also would reduce the Federal Medical Assistance Percentages for the fourteen remaining non-expansion states and permanently authorize the Children's Health Insurance Program.	**06/30/2020** Passed the House; Referred to the Senate **02/22/2020** Introduced	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 910 Wood	**Mental Health Services Dispute Resolution:** Would provide the Department of Health Care Services (DHCS) more authority to resolve coverage disputes between the specialty mental health plan (MHP) and the Medi-Cal managed care plan (MCP) if the MHP and the MCP are unable to do so within 15 days. Would require the MHP and the MCP to continue to provide mental health services during the DHCS review period. DHCS would have no more than 30 days to resolve the dispute to determine which agency is responsible for that Medi-Cal beneficiary.	**01/30/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2265 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2266, would authorize MHSA funds to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The authorization would apply across the state. Additionally, would require the county that elects to utilize MHSA funding for this purpose to report the number of people assessed for cooccurring mental health and substance use disorders and the number of those assessed who only have a substance use disorder to the Department of Health Care Services.	**06/02/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2266 Quirk-Silva	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Similar to AB 2265, would authorize MHSA funds to be used for a pilot program to provide care for an individual experiencing a behavioral health-related issue that cooccurs with a substance use disorder. The pilot program would take place in 10 counties, including the County of Orange, beginning January 1, 2022 and ending on December 31, 2026.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2576 Gloria	**Mental Health Services Act (MHSA) Use of Funds for Homelessness:** Would require a county to seek stakeholder input when establishing a plan to reallocate the use of MHSA funds. Additionally, would require counties utilizing MHSA funds for the provision of mental health services for those experiencing homelessness to report to the Legislature, each year, the number of individuals receiving services.	**07/01/2020** Referred to Senate Committee on Health **06/15/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 803 Beall	**Mental Health Services Act (MHSA) Funds for Cooccurring Conditions:** Would create the Certified Support Specialist (CSS) certificate program. Would allow parents, peers, and family, 18 years of age or older and who have experienced a mental illness and/or a substance use disorder, to become a CSS. A CSS would be able to provide non-medical mental health and substance abuse support services. Additionally, would require the Department of Health Care Services to include CSS as a provider type, covered by Medi-Cal, no sooner than January 1, 2022. If federally approved, the peer-support program would be funded through Medi-Cal reimbursement.	**06/18/2020** Passed Committee on Appropriations **05/13/2020** Passed Committee on Health **01/08/2020** Introduced	CalOptima: Watch LHPC: Support
SB 1254 Moorlach	**Capacity Determinations and Appointments of Guardians Ad Litem for Mentally Ill Adults Without a Conservator:** Would establish an additional procedure for the appointment of a guardian ad litem for a person who lacks the capacity to make rational informed decisions regarding medical care, mental health care, safety, hygiene, shelter, food, or clothing with a rational thought process due to a mental illness, defect, or deficiency. The bill would authorize certain persons to petition the court for the appointment of a guardian ad litem under these provisions.	**05/22/2020** Hearing canceled at the request of the author. **05/11/2020** Referred to Committee on Judiciary **02/21/2020** Introduced	CalOptima: Watch

BLOOD LEAD SCREENINGS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2276 Reyes	**Blood Lead Screening Tests Age Guidelines:** Would require the Medi-Cal managed care plan (MCP) to conduct blood lead screening tests for a Medi-Cal beneficiary at 12 and 24 months of age. This would require the MCP to contract with providers qualified to conduct any blood level screening tests and for the MCP to notify the beneficiary's parent or guardian that the beneficiary is eligible for blood lead screening tests. Additionally, if a child two to six years of age does not have medical records stating the completion of a blood lead screening test, the MCP would be required to provide at least one blood lead screening test. The MCP would also be required to report to the Department of Health Care Services (DHCS) the number of beneficiaries aged one and two who have received a blood lead screening test and of any associated case management services provided.	**07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2277 Salas	**Blood Lead Screening Tests Contracted Providers:** Would require the Medi-Cal managed care plan (MCP) to identify beneficiaries who have missed a blood screening test at both 12 and 24 months of age and impose requirements of the contracted provider to conduct blood lead screenings tests for those eligible to receive such tests. Would require the MCP to remind the contracted provider to conduct blood lead screening tests on a quarterly basis and to notify the beneficiary's parent, parents, guardian, or other person responsible for their care that the beneficiary is eligible to receive a blood screening test.	**07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2278 Quirk	**Childhood Lead Poisoning Prevention Health Plan Identification:** Would require the name of the health plan financially liable for conducting blood lead screenings tests to be reported by the laboratory to the Department of Health Care Services once the screening test has been completed. The name of the health plan is to be reported for each Medi-Cal beneficiary who receives the blood lead screen tests.	**02/24/2020** Referred to Committee on Health **02/14/2020** Introduced	CalOptima: Watch
AB 2279 Garcia	**Childhood Lead Poisoning Prevention Risk Factors:** Would require the following risk factors be included in the standard risk factors guide, which are to be considered during each beneficiary's periodic health assessment: ■ A child's residency or visit to a foreign country ■ A child's residency in a high-risk ZIP Code ■ A child's relative who has been exposed to lead poisoning ■ The likelihood of a child placing nonfood items in the mouth ■ A child's proximity to current or former lead-producing facilities ■ The likelihood of a child using food, medicine, or dishes from other countries	**06/23/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/14/2020** Introduced	CalOptima: Watch
AB 2422 Grayson	**Blood Lead Screening Tests Medi-Cal Identification Number:** Would require the Medi-Cal identification number to be added to the list of patient identification information collected during each blood test. Would require the laboratory conducting the blood lead screening tests to report all patient identification information to the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch
SB 1008 Leyva	**Childhood Lead Poisoning Prevention Act Online Registry:** Would require the Department of Public Health to design, implement, and maintain an online lead information registry available to the general public. Would require the information registry to include items such as the location and status of properties being inspected for lead contaminants.	**03/05/2020** Referred to Committees on Health; Judiciary **02/14/2020** Introduced	CalOptima: Watch

CALIFORNIA ADVANCING AND INNOVATING MEDI-CAL (CALAIM)

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2042 Wood	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to SB 916, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch
AB 2055 Wood	**CalAIM Drug Medi-Cal and Behavioral Health:** Would require the Department of Health Care Services to establish the Behavioral Health Quality Improvement Program. The Behavioral Health Quality Improvement Program would be responsible for providing support to entities managing the Drug Medi-Cal program as they prepare for any changes directed by the CalAIM initiative. Additionally, would establish a voluntary intergovernmental transfer (IGT) program relating to substance use disorder treatment provided by counties under the Drug Medi-Cal program. The IGT program would fund the nonfederal share of supplemental payments and to replace claims based on certified public expenditures.	**03/12/2020** Referred to Committee on Health **02/03/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2170 Blanco Rubio	**CalAIM Medi-Cal Eligibility for Juveniles Who are Incarcerated:** Would require the county welfare department to conduct a redetermination of eligibility for juveniles who are incarcerated so that, if eligible, their Medi-Cal would be reinstated immediately upon release.	**02/20/2020** Referred to Committee on Health **02/11/2020** Introduced	CalOptima: Watch
SB 910 Pan	**CalAIM Population Health Management:** Would require Medi-Cal managed care plans (MCPs) to implement the population health management program for those deemed eligible, effective January 1, 2022. Would require the Department of Health Care Services to utilize an external quality review organization (EQRO) to evaluate the effectiveness of the enhanced care management and in-lieu-of services provided to beneficiaries by each MCP. Additionally, would require each MCP to consult with stakeholders, including, but not limited to, county behavioral health departments, public health departments, providers, community-based organizations, consumer advocates, and Medi-Cal beneficiaries, on developing and implementing the population health management program.	**02/03/2020** Introduced	CalOptima: Watch
SB 916 Pan	**CalAIM Enhanced Care Management and In-Lieu-Of Services:** Similar to AB 2042, would require enhanced care management as a covered benefit for Medi-Cal beneficiaries, including the coordination of all primary, acute, behavioral, oral, and long-term services and supports. Additionally, would require the Medi-Cal managed care plan to include a variety of in-lieu-of services as an optional benefit for beneficiaries posted on their website and in the beneficiary handbook.	**02/03/2020** Introduced	CalOptima: Watch

COVERED BENEFITS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4618 McBath	**Medicare Hearing Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of hearing aids for Medicare beneficiaries. Hearing aids would be provided every five years and would require a prescription from a doctor or qualified audiologist.	**10/17/2019** Passed the Committee on Energy and Commerce **10/08/2019** Introduced	CalOptima: Watch
H.R. 4650 Kelly	**Medicare Dental Act of 2019:** Effective no sooner than January 1, 2022, would require Medicare Part B to cover the cost of dental health services for Medicare beneficiaries. Covered benefits would include preventive and screening services, basic and major treatments, and other care related to oral health.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch
H.R. 4665 Schrier	**Medicare Vision Act of 2019:** No sooner than January 1, 2022, would require Medicare Part B to cover the cost of vision care for Medicare beneficiaries. Covered benefits would include routine eye exams and corrective lenses. Corrective lenses covered would be either one pair of conventional eyeglasses or contact lenses.	**10/17/2019** Passed the Committee on Energy and Commerce **10/11/2019** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1904 Boerner Horvath	**Maternal Physical Therapy:** Would include pelvic floor physical therapy for women post-pregnancy as a Medi-Cal benefit.	**01/17/2020** Referred to Committee on Health **01/08/2020** Introduced	CalOptima: Watch
AB 1965 Aguiar-Curry	**Human Papillomavirus (HPV) Vaccine:** Would expand comprehensive clinical family planning services under the program to include the HPV vaccine for persons of reproductive age.	**03/17/2020** Hearing canceled at the request of the author **01/30/2020** Referred to Committee on Health **01/21/2020** Introduced	CalOptima: Watch
AB 2258 Reyes	**Doula Care:** Would require full-spectrum doula care to be included as a covered benefit for pregnant and postpartum Medi-Cal beneficiaries. The program would be established as a 3-year pilot program in 14 counties, including the County of Orange, beginning July 1, 2021. Prior authorization or cost-sharing to receive doula care would not be required.	**02/20/2020** Referred to Committee on Health **02/13/2020** Introduced	CalOptima: Watch

DENTAL

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2535 Mathis	**Denti-Cal Education Pilot Program:** Would establish a 5-year pilot program to provide education and training to Denti-Cal providers providing care to individuals who attend a regional center and are living with a developmental disability. Additionally, Denti-Cal providers who participate in the pilot program and complete the required continuing education units would be eligible for a supplemental provider payment. The supplemental provider payment amount has yet to be defined by the Department of Health Care Services.	**02/27/2020** Referred to Committee on Health **02/19/2020** Introduced	CalOptima: Watch

ELIGIBILITY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 4 Arambula	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals of all ages regardless of their immigration status. The Legislative Analyst's Office projects this expansion would cost approximately $900 million General Fund (GF) in 2019-2020 and $3.2 billion GF each year thereafter, including the costs if In-Home Supportive Services.	**07/02/2019** Hearing canceled at the request of the author **06/06/2019** Referred to Senate Committee on Health **05/28/2019** Passed Assembly floor **12/03/2018** Introduced	CalOptima: Watch CAHP: Support LHPC: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 526 Petrie-Norris	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to SB 1073, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, 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 through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**08/30/2019** Senate Committee on Appropriations; Held under submission **06/27/2019** Passed Senate Committee on Health **05/23/2019** Passed Assembly floor **02/13/2019** Introduced	CalOptima: Watch
AB 683 Carrillo	**Adjusting the Assets Test for Medi-Cal Eligibility:** Would eliminate specific assets tests, such as life insurance policies, musical instruments, and living trusts, when determining eligibility for Medi-Cal enrollment, effective July 1, 2020. Additionally, would prohibit the Department of Health Care Services from using an asset and resource test when determining eligibility for Medi-Cal enrollment when the individual is enrolled in the Medicare Shared Savings Program, effective January 1, 2020.	**06/23/2020** Referred to Senate Committee on Health **01/20/2020** Passed Assembly floor; Referred to Senate floor **02/15/2019** Introduced	CalOptima: Watch
SB 29 Durazo	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals ages 65 years or older, regardless of their immigration status. The Assembly Appropriations Committee projects this expansion would cost approximately $134 million each year ($100 million General Fund, $21 federal funds) by expanding full-scope Medi-Cal to approximately 25,000 adults who are undocumented and 65 years of age and older. The financial costs for In-Home Supportive Services is estimated to cost $13 million General Fund.	**09/13/2019** Held in Assembly **05/29/2019** Passed Senate floor **12/03/2018** Introduced	CalOptima: Watch
SB 1073 Gonzalez	**Women, Infants, and Children (WIC) to Medi-Cal Express Lane:** Similar to AB 526, would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for WIC to Medi-Cal. WIC, within the Children's Health Insurance Program, 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 through the express lane. Of note, the express lane program was never implemented due to a lack of funding.	**04/03/2020** Referred to Committee on Health **02/18/2020** Introduced	CalOptima: Watch

HOMELESSNESS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 1978 Correa/Lieu	**Fighting Homelessness Through Services and Housing Act:** Similar to S. 923, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to the House Committee on Financial Services	CalOptima: Watch
S. 923 Feinstein	**Fighting Homelessness Through Services and Housing Act:** Similar to H.R. 1978, would establish a federal grant program within the Health Resources and Services Administration to fund comprehensive homeless support services through the appropriation of $750 million each year for five years, beginning in FY 2020. Included would be a one-time grant of $100,000 to support program planning for existing programs serving those who are homeless or at risk of being homeless. Each eligible entity would be able to receive up to $25 million each year for up to five years. Government entities eligible to apply for grant funding would include counties, cities, regional or local agencies, Indian tribes or tribal organizations. Each agency would be able to enter partnerships to meet eligibility status. Additionally, comprehensive homeless support services, such as mental health services, supportive housing, transitional support, and case management must be provided by the agency to be considered to receive grant funding. Individuals eligible to receive comprehensive homeless support services through this program include persons who are homeless or are at risk of becoming homeless, including families, individuals, children and youths.	**03/28/2019** Introduced; Referred to Committee on Health, Education, Labor, and Pensions	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1907 Santiago, Gipson, Quirk-Silva	**California Environmental Quality Act (CEQA) Exemption for Emergency Shelters and Supportive Housing:** Would exempt the development of emergency shelters, supportive housing or affordable housing by a public agency from CEQA regulations, expiring on December 31, 2028.	**05/13/2020** Hearing canceled at the request of the author **01/30/2020** Referred to Committees on Natural Resources; Housing and Community Development **01/08/2020** Introduced	CalOptima: Watch
AB 2295 Quirk-Silva	**Fairview Developmental Center:** Would require the State Legislature to enact legislation relating to the development of the Fairview Developmental Center (Center) located in Costa Mesa, CA. Of note, the Governor's Fiscal Year 2019-2020 budget included funds to utilize the Center temporarily to provide housing and services for those experiencing a severe mental illness. Additionally, AB 1199, signed into law in 2019, allows a public hearing to determine the use of the Center. This bill is still early in the legislative process. The pending legislation to define use of the Center is unknown at this time.	**02/14/2020** Introduced	CalOptima: Watch
AB 2746 Petrie-Norris, Gabriel	**Accountability of State Funds Used for Homelessness:** Would require an agency that receives state funds for programs related to homelessness, including, but not limited to, the Whole-Person Care pilot program, California Work Opportunity and Responsibility to Kids (CalWORKs), or the Housing and Disability Income Advocacy Program, to submit a report regarding the use of state funds. The report would be sent to the state agency granting funds for these programs. Additionally, would require the report to the state agencies to be submitted within 90 days of receiving program funds, or by April 1, 2021, if the recipient already received program funds as of January 1, 2021.	**07/01/2020** Referred to Senate Committee on Human Services **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/20/2020** Introduced	CalOptima: Watch
AB 2848 Santiago	**Homelessness Reduction Plan:** Would require each city or county to develop a plan to reduce homelessness by no less than 10% each year through a state mandate. The plan would be effective no later than January 1, 2022 and would be under the direction of the state's Homeless Coordinating and Financing Council. Additionally, would authorize the Office of the Inspector General to be in compliance with the Homeless Reduction Plan.	**05/05/2020** Re-referred to Committee on Housing and Community Development **02/20/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 3269 Chiu, Bloom, Bonta, Quirk-Silva, Santiago	**State and Local Homelessness Reduction Plan:** Would require the State Homeless Coordinating and Financing Council (coordinating council) to seek federal support from the Department of Housing and Urban Development (HUD), if available, to conduct a statewide needs and gaps analysis relating to homelessness. Would require the coordinating council to identify state programs that provide housing or services to individuals experiencing homelessness. With that information, would require the coordinating council to collaborate with HUD to create a financial model that will assess the costs of providing transitional support into permanent housing for those experiencing homelessness. Furthermore, this bill would require state and local agencies aim at reducing homelessness by 90% by December 31, 2028, based on the 2019 homeless point-in-time count. Would establish the Office of the Housing and Homelessness Inspector General to monitor the reduction plan and to bring action against a state and local agency that fails to adopt and implement a homelessness reduction plan within a reasonable time frame. Additionally, on or before January 1, 2022, each state and local agency shall develop an actionable plan to reduce homelessness and submit that plan to the Homeless Coordinating and Financing Council. This bill would also require HUD to set a benchmark goal for the reduction plan for each state and local agency to meet by January 1, 2028.	**07/02/2020** Referred to Senate Committee on Housing **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/21/2020** Introduced	CalOptima: Watch
AB 3300 Bloom, Bonta, Gipson, Quirk-Silva, Santiago, Wicks	**California Access to Housing and Services Act:** Would authorize the Department of Finance to allocate no more than $2 billion General Fund to establish the California Access to Housing and Services Fund.	**07/01/2020** Referred to Senate Committee on Housing **06/15/2020** Passed Assembly floor; Referred to Senate floor **02/21/2020** Introduced	CalOptima: Watch

MEDI-CAL MANAGED CARE PLANS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2625 Boerner Horvath	**Ground Emergency Medical Transportation (GEMT):** Would require managed care plans that offers coverage for GEMT services to include those services as in-network services.	**03/02/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2836 Chen	**Medi-Cal Emergency Medical Transportation Reimbursement Act:** Would impose a quality assurance fee (QAF) for each emergency medical transport provided by an emergency medical transport provider, beginning Fiscal Year 2021-2022. Would require the Department of Health Care Services to calculate the annual QAF to a specified program period at least 150 days before the start of the fiscal year. The bill would also redefine "emergency medical transport provider" to mean any provider of emergency medical transports, except during the entirety of any Medi-Cal managed care rating period.	**05/05/2020** Referred to Committee on Health **02/20/2020** Introduced	CalOptima: Watch
SB 936 Pan	**Medi-Cal Managed Care Plans Contract Procurement:** Would require the Department of Health Care Services Director to conduct a contract procurement at least once every five years with a contracted commercial Medi-Cal managed care plan providing care for Medi-Cal beneficiaries on a state-wide or limited geographic basis.	**02/20/2020** Referred to Committee on Health **02/06/2020** Introduced	CalOptima: Watch

PHARMACY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 1938 Low, Eggman	**340B Discount Drug Purchasing Program:** Would define a "designated entity" eligible for the 340B discount drug purchasing program as a nonprofit organization, including any subsidiary of that organization, that individually or collectively meets specific requirements. This would require: ■ The designated entity to be a licensed managed care organization that has previously contracted with the department as a primary care case management organization; ■ The designated entity to be contracted with the federal Centers for Medicare and& Medicaid Services (CMS) to provide services in the Medicare Program as a Medicare special needs plan; and ■ The designated entity to be an existing participant of the 340B program. Additionally, would prohibit a designated entity from using any revenue from a contract with the Department of Health Care Services, a contract with CMS, and from the 340B program for specific activities, such as: ■ Funding litigation under the California Environmental Quality Act; or ■ Influencing or funding any ballot measure actions related to housing.	**05/19/2020** Passed Committee on Health; Referred to Committee on Appropriations **01/17/2020** Introduced	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2100 Wood	**Pharmacy Carve-Out Benefit:** Would require the Department of Health Care Services to establish the Independent Prescription Drug Medical Review System (IPDMRS) for the outpatient pharmacy benefit, and to develop a framework for the system that models the requirements of the Knox-Keene Health Care Service Plan Act. Would require the IPDMRS to review disputed health care service of any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed or to a finding that the service is not medically necessary. Additionally, would establish prior authorization requirements, such as a 24-hour response, a 72-hour supply during emergency situations, and a minimum 180 days for continuity of care for medications regardless if listed on the Medi-Cal contract drug list.	**07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/05/2020** Introduced	CalOptima: Watch
AB 2348 Wood	**Pharmacy Benefit Management (PBM):** Would require a PBM, who contracts with a health care service plan, beginning on October 1, 2021, to report to the Department of Managed Health Care the PBM's revenue, expenses, health care service plan contracts, the scope of services provided to that plan, and the number of enrollees the PBM serves. The PBM would also be required to submit a report on all covered prescription drugs, including generic, brand name, and specialty drugs dispenses at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use.	**05/05/2020** Referred to the Committee on Health **02/18/2020** Introduced	CalOptima: Watch
SB 852 Pan	**California Affordable Drug Manufacturing Act of 2020:** Would establish the Office of Drug Contracting and Manufacturing (Office) to reduce the cost of prescription drugs. No later than January 1, 2022, would require the Office to contract or partner with no less than one drug company or generic drug manufacturer, licensed by the United States Food and Drug Administration, to produce or distribute generic prescription drugs.	**06/18/2020** Passed Committee on Appropriations; Referred to Senate floor **05/13/2020** Passed Committee on Health **01/13/2020** Introduced	CalOptima: Watch CAHP: Support
SB 1084 Umberg	**Secure Dispensing of a Controlled Substance:** Would require a pharmacist who dispenses a controlled substance in a pill form to dispense the controlled substance in a lockable vial no sooner than June 30, 2021. Would require the manufacturer of the controlled substance to reimburse the pharmacy dispensing the medication the cost of using a lockable vial within 30 days of receiving a claim. Would also require the pharmacy to provide educational pamphlets to the patient regarding the use of a controlled substance.	**03/05/2020** Referred to Committees on Business, Professions and Economic Development; Judiciary **02/19/2020** Introduced	CalOptima: Watch

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 2492 Choi	**Program of All-Inclusive Care for the Elderly (PACE) Enrollment:** Would require the Department of Health Care Services to establish a maximum number of eligible participants each PACE center can enroll.	**03/17/2020** Hearing postponed by Committee on Aging & Long-Term Care **03/12/2020** Referred to Committees on Health; Aging & Long-Term Care **02/19/2019** Introduced	CalOptima: Watch CalPACE: Oppose
AB 2604 Carrillo	Pandemic and Health-Related Emergency Protocols for Health Facilities Act: During a health-related state of emergency or local emergency, would require a health facility to limit the possible introduction of a pathogen, infection, or illness that is related to a pandemic or emergency by: ■ Postponing non-emergency medical procedures or office visits; ■ Prohibiting or limiting visitors of patients to the health facility; ■ Ensuring all patients and staff are always wearing surgical masks or personal protective equipment; ■ Providing education and enforcing regarding hand hygiene and cough etiquette for patients and staff; ■ Regularly disinfecting the health facility at least three times per day; ■ Adding air cleaning equipment to ventilation systems; ■ Establishing contaminated, partially contaminated, and clean zones with buffers between each of the three zones; ■ Implementing outdoor triage stations; and ■ Considering all patients to have "suspected cases' of the pathogen, infection, or illness until ruled out or confirmed.	**05/07/2020** Re-referred to Committee on Labor and Employment **02/21/2020** Introduced	CalOptima: Watch

PROVIDERS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
AB 890 Wood	**Nurse Practitioners:** Would permit a nurse practitioner to practice without direct, ongoing supervision of a physician when practicing in an office managed by one or more physicians. Would, until January 1, 2026, create the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs to certify nurse practitioners wanting to practice without direct, ongoing supervision of one or more physicians.	**06/23/2020** Referred to Senate Committee on Business, Professions and Economic Development **01/27/2019** Passed Assembly floor **02/20/2019** Introduced	CalOptima: Watch LHPC: Support

REIMBURSEMENT RATES

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 66 Atkins/ McGuire	**Federally Qualified Health Center (FQHC) Reimbursement**: Would allow an FQHC to be reimbursed by the state for a mental health or dental health visit that occurs on the same day as a medical face-to-face visit. Currently, California is one of the few states that do not allow an FQHC to be reimbursed for a mental or dental and physical health visits on the same day. A patient must seek mental health or dental treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would distinguish a medical visit through the member's primary care provider and a mental health or dental visit as two separate visits, regardless if at the same location on the same day. As a result, the patient would no longer have to wait a 24-hour time period in order to receive medical and dental or mental health services, while ensuring that clinics are appropriately reimbursed for both services. Additionally, acupuncture services would be included as a covered benefit when provided at an FQHC.	**09/13/2019** Carry-over bill; Moved to inactive filed at the request of the author **08/30/2019** Passed Assembly Committee on Appropriations **05/23/2019** Passed Senate floor **01/08/2019** Introduced	CalOptima: Watch CAHP: Support LHPC: Co-Sponsor, Support
AB 2871 Fong	**Drug Medi-Cal Reimbursement Rates:** Would require the Department of Health Care Services to establish reimbursement rates for services provided through the Drug Medi-Cal program to be equal to rates for similar services provided through the Medi-Cal Specialty Mental Health Services program.	**03/05/2020** Referred to Committee on Health **02/21/2020** Introduced	CalOptima: Watch

TELEHEALTH

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
H.R. 4932 Thompson	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to S. 2741, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Committees on Energy and Commerce; Ways and Means	CalOptima: Watch AHIP: Support

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
S. 2741 Schatz	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019:** Similar to H.R. 4932, would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Would also: ■ Provide the Secretary of Health and Human Services with the authority to waive telehealth restrictions when necessary; ■ Remove geographic and originating site restrictions for services like mental health and emergency medical care; ■ Allow rural health clinics and other community-based health care centers to provide telehealth services; and ■ Require a study to explore more ways to expand telehealth services so that more people can access health care services in their own homes.	**10/30/2019** Introduced; Referred to the Senate Committee on Finance	CalOptima: Watch AHIP: Support
AB 1676 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours. Would also require adequate staffing to ensure calls are answered within 60 seconds. Payment structure has yet to be defined.	**01/31/2020** Died in appropriations **05/16/2019** Committee on Appropriations; Held under submission **04/24/2019** Passed Committee on Health **02/22/2019** Introduced	CalOptima: Watch CAHP: Oppose
AB 2164 Rivas, Salas	**Expanding Access to Telehealth:** Would no longer require the first visit at a federally qualified health clinic to be an in-person visit by authorizing telehealth appointments that occur by synchronous real time or asynchronous store and forward. This would allow the new patient the option to utilize telehealth services and become an established patient as their first visit.	**07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/11/2020** Introduced	CalOptima: Watch
AB 2360 Maienschein	**Telehealth Mental Health Services for Children, Pregnant Women, and Postpartum Persons:** Similar to AB 1676, which was held under submission by the Assembly Committee on Appropriations in 2019, would create a telehealth program used to conduct mental health consultations and treatments for children, pregnant women, and postpartum persons, effective no sooner than January 1, 2021. Consultation and treatment services, provided by a psychiatrist, would be accessible during standard business hours, with the option for evening and weekend hours.	**07/01/2020** Referred to Senate Committee on Health **06/10/2020** Passed Assembly floor; Referred to Senate floor **02/19/2020** Introduced	CalOptima: Watch CAHP: Oppose

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
SB 1278 Bradford	**Health Care Provider License for Telehealth:** Would require that accepted standards of practice applicable to a health care provider under the health care provider's license shall also apply to that health care provider while providing telehealth services.	**05/15/2020** Hearing canceled at the request of the author **03/05/2020** Referred to Committee on Business, Professions and Economic Development **02/21/2020** Introduced	CalOptima: Watch

TRAILER BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Medi-Cal Expansion	**Medi-Cal Eligibility Expansion:** Would extend eligibility for full-scope Medi-Cal to eligible individuals 65 years of age or older regardless of their immigration status. The Governor's Fiscal Year 2020-2021 proposed budget anticipates the expansion of full-scope Medi-Cal will cost $80.5 million ($62.4 million General Fund) in 2021 and $350 million ($320 million General Fund) each year after, including the cost of In-Home Supportive Services.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Drug Price Negotiations	**Med-Cal Drug Pricing Negotiations:** Would authorize the Department of Health Care Services negotiate "best prices" with drug manufacturers, both within and outside of the United States, and to establish and administer a drug rebate program in order to collect rebate payments from drug manufacturers for drugs furnished to California residents who are ineligible for full-scope Medi-Cal. Would authorize a Medi-Cal beneficiary to receive more than six medications without prior approvals. Additionally, this Trailer Bill would modify the current co-pay amount for a drug prescription refill.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Medication-Assisted Treatment	**Medication-Assisted Treatment (MAT):** Would expand narcotic treatment program services to include MAT under Drug Medi-Cal.	**01/31/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Managed Care Savings and Efficiencies	**Managed Care Savings and Efficiencies:** In alignment with the 2020-2021 State Budget May Revise, would reduce Medi-Cal capitation rate increments by up to 1.5 percent for capitation rates associated with the July 1, 2019 through December 31, 2020 rate period. Additionally, the Department of Health Care Services (DHCS) would be able to apply these reduced capitation rates for rating periods starting on or after January 1, 2021 and to account for the impacts of the COVD-19 public health emergency. To ensure capitation rates are actuarily sound, DHCS would be required to evaluate the impact of the changes in the level of health care funding for health care services on capitation rates it develops and pays under any applicable managed care health plan contract with a Medi-Cal managed care plan.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes*
Trailer Bill Federally Qualified Health Center and Rural Health Clinic Prospective Payment System Carve-Outs	**Elimination of Federally Qualified Health Center (FQHC) and Rural Health Clinic (RHC) Prospective Payment System (PPS) Carve-Outs for Pharmacy and Dental Services:** Would require all Medi-Cal covered services provided by an FQHC or RHC, including but not limited to pharmacy and dental services, to be reimbursed only through the clinic's PPS rate, effective January 1, 2021. If an FQHC or RHC is unable to revert to its prior base PPS rate, it would be required to adjust the FQHC or RHC PPS base rate through scope-of-service adjustments. Of note, this Trailer Bill language would exclude any payment changes for services related to specialty mental health and Drug Medi-Cal.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Proposition 56 Payments	**Sunset of Proposition 56 Value-Based Payments:** In alignment with the 2020-2021 State Budget May Revise, would eliminate the Proposition 56 Value-Based Payment Program for provider incentive payments, effective July 1, 2020.	**05/14/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill COVID-19 Medi-Cal Response	**COVID-19 Medi-Cal Response:** Would require the Department of Health Care Services to implement any federal Medicaid program waivers or flexibilities approved by the Centers for Medicare & Medicaid Services related to the COVID-19 pandemic, pending approval from the State Department of Finance. Additionally, would require DHCS to continue providing COVID-19 related testing and treatment for individuals currently uninsured, regardless of immigration status, through Medi-Cal fee-for-service. This would be in effect for the duration of the State of Emergency.	**05/22/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Nursing Facility Financing Reform	**Nursing Facility Financing Reform:** Would make modifications to the skilled nursing facility (SNF) Quality Assurance Fees (QAFs): ■ Would exempt a unit that provides freestanding pediatric subacute care services in a SNF from the QAF for the rate period of August 1, 20202 through December 31, 2020, and every subsequent calendar year after; ■ Would allow the Department of Health Care Services (DHCS) to enforce new mechanisms for the collection of delinquent QAFs; and ■ Expand the use of the SNF Quality and Accountability Special Fund to December 31, 2021. Additionally, would adjust the Medi-Cal reimbursement rate methodology for the rate period of August 1, 2020 to December 31, 2020 to be no less than the rates established for 2019-2020 and no more than the applicable federal upper payment limit.	**05/26/2020** Published on the Department of Finance website	CalOptima: Watch
Trailer Bill Long-Term Care at Home	**Long-Term Care at Home:** Would include long-term care services at home as a Medi-Cal covered benefit for beneficiaries enrolled in managed care and fee-for-service. Would require the entity providing long-term care at home benefits to be licensed and certified by the California Department of Public Health. Additionally, would require the benefit to include services such as, health assessments, transitional care services, care coordination, and home- and community-based services.	**06/12/2020** Published on the Department of Finance website	CalOptima: Watch

*Information in this document is subject to change as bills are still going through the early stages of the legislative process.

CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

2020 Federal Legislative Dates

April 4–19	Spring recess
August 10–September 7	Summer recess
October 12–November 6	Fall recess

2020 State Legislative Dates*

**Due to COVID-19, 2020 State Legislative dates have been modified*

January 6	Legislature reconvenes
January 31	Last day for bills introduced in 2019 to pass their house of origin
February 21	Last day for legislation to be introduced
April 2–12	Spring recess
May 22	Last day for policy committees to hear and report bills to fiscal committees introduced in the Assembly
May 29	Last day for policy committees to hear and report bills to fiscal committees introduced in the Senate
May 29	Last day for policy committees to hear and report to the floor non-fiscal bills introduced in the Assembly
June 5	Last day for fiscal committees hear and report to the floor bills introduced in the Assembly
June 15	Budget bill must be passed by midnight
June 15–19	Assembly floor session only
June 19	Last day for the Assembly to pass bills in their house of origin
June 19	Last day for fiscal committees to hear and report to the floor bills introduced in the Senate
June 22–26	Senate floor session only
June 26	Last day for the Senate to pass bills in their house of origin
July 2–July 27	Summer recess
July 31	Last day for policy committees to hear and report fiscal bills to fiscal committees
August 7	Last day for policy committees to meet and report bills to the floor
August 14	Last day for fiscal committees to report bills to the floor
August 17–31	Floor session only
August 21	Last day to amend bills on the floor
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 3	General Election
December 7	Convening of the 2021–22 session

Sources: 2020 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities. As Orange County's community health plan, our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. We provide coverage through four major programs: Medi-Cal, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan), OneCare (Medicare Advantage Special Needs Plan), and the Program of All-Inclusive Care for the Elderly (PACE).

Board of Directors Meeting
August 6, 2020

CalOptima Community Outreach Summary — June and July 2020

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 and 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 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's 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 Event Update

In FY 2019–2020, the Community Relations department received and processed 183 requests for CalOptima to participate in community events. Approximately 61% (112 out of 183) of the requests met at least one of the criteria required as detailed in Policy AA.1223 Participation in Community Events Involving External Entities and staff and/or volunteers were available to attend. Four of these community events transitioned to a virtual platform where CalOptima participated; three events were provided financial participation. CalOptima did not participate in approximately 39% (71 out of 183) of the community event requests due to limited staff availability, short notice, change of format or when events were cancelled. With that, nearly 4 events scheduled from mid-March to June 30, 2020 were cancelled or postponed due to COVID-19.

Community events attended include health and community resource fairs, back-to-school events, conferences and community celebrations throughout Orange County. These community events provided CalOptima staff opportunities to engage with current and potential members of all ages and ethnic backgrounds. During these events, staff shares information about CalOptima, Medi-Cal benefits and support services available to CalOptima members. Approximately 51% of these events provided outreach to families, adults, children and the general public, 31% outreached to seniors and people with disabilities, 3% outreached to foster children and homeless individuals/families and 2% outreached to veterans and their families. The remaining 13% of the

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events were educational seminars and conferences where staff shared information with professionals and the provider community.

CalOptima provided $70,765 in the form of sponsorships and registration fees for 51 community events (42 events totaling $63,695 for outreach to members and/or potential members, and nine community events totaling $7,070 for outreach to health care professionals, non-profit organizations and policy makers). Financial support for these community events increased CalOptima's visibility in the community while strengthening our collaborative partnerships with requesting entities. Sponsorships provided marketing benefits and promoted awareness of CalOptima and Medi-Cal's programs and services with members and potential members. An additional $12,600 in financial support previously provided for events that were cancelled or postponed due to COVID-19 is expected to be used by organizers during the 2020–2021 Fiscal Year.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities
CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

As of June 24, 2020, **through virtual meetings and teleconferences** CalOptima expects to participate in 50 community events, coalition and committee meetings during June and July.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
6/02/2020	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
6/03/2020	• Orange County Aging Services Collaborative Meeting (Virtual Meeting) • Orange County Women's Health Summit: COVID-19 and Sexual Health (Sponsorship Fee: $1,000 included agency's logo and information in digital program, recognition of agency's sponsorship throughout virtual event.) (Virtual Conference)
6/04/2020	• Garden Grove Community Collaborative Advisory Meeting (Virtual Meeting)
6/08/2020	• Orange County Veteran's and Military Families Collaborative Meeting (Virtual Meeting) • Fullerton Collaborative Meeting (Virtual Meeting)
6/09/2020	• Orange County Cancer Coalition Meeting (Virtual Meeting)
6/10/2020	• Vietnamese American Service Providers Networking Meeting (Teleconference) • Orange County Women's Health Summit: COVID-19 and Women's Health Policy Implications (Sponsorship Fee: $1,000 included agency's logo and information in digital program, recognition of agency's sponsorship throughout virtual event.) (Virtual Conference)

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6/11/2020	• Kid Healthy Community Advisory Council (Virtual Meeting) • Garden Grove Community Collaborative General Meeting (Virtual Meeting) • Buena Park Collaborative Meeting (Virtual Meeting) • Orange County Strategic Plan for Aging (Virtual Meeting)
6/15/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee (Pending format)
6/16/2020	• Placentia Community Collaborative Meeting (Virtual Meeting)
6/17/2020	• Orange County Communications Workgroup Meeting (Teleconference) • Covered Orange County Steering Committee Meeting (Teleconference) • Orange County Women's Health Summit: COVID-19 and Mental Health (Sponsorship Fee: $1,000 included agency's logo and information in digital program, recognition of agency's sponsorship throughout virtual event.) (Virtual Conference) • Orange County Veterans and Military Families Collaborative General Meeting (Virtual Meeting)
6/18/2020	• Orange County Children's Partnership Committee Meeting (Virtual Meeting)
6/22/2020	• Stanton Collaborative Meeting (Virtual Meeting)
6/25/2020	• Orange County Care Coordination for Kids (Virtual Meeting) • Orange County Women's Health Project Advisory Committee (Teleconference) • Kid Healthy Community Advisory Council (Virtual Meeting)
6/26/2020	• Connection Cafe (Virtual Meeting) • Orange County Veterans and Military Families Collaborative, Health and Wellness Subcommittee Meeting (Virtual Meeting)
7/2/2020	• Continuum of Care Homeless Provider Forum (Virtual Meeting)
7/7/2020	• Collaborative to Assist Motel Families Meeting (Virtual Meeting)
7/8/2020	• Anaheim Homeless Collaborative Meeting (Format Pending) • Health Care Task Force Meeting (Format Pending)
7/9/2020	• Garden Grove Community Collaborative General Meeting (Virtual Meeting) • State Council on Developmental Disabilities Regional Advisory Committee Meeting (Pending Format) • Buena Park Collaborative Meeting (Virtual Meeting) • Kid Healthy Community Advisory Council (Virtual Meeting)

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7/10/2020	• Orange County Diabetes Coalition Meeting (Pending Format)
7/13/2020	• Orange County Veterans and Military Families Collaborative, Children and Family Working Group Meeting (Virtual Meeting)
7/14/2020	• Orange County Cancer Coalition Meeting (Virtual Meeting) • Wellness and Prevention Coalition Meeting (Virtual Meeting)
7/15/2020	• Covered Orange County Steering Committee Meeting (Teleconference) • Orange County Communications Workgroup Meeting (Teleconference)
7/16/2020	• Orange County Disability Coalition Meeting (Virtual Meeting) • Orange County Women's Health Project Advisory Committee (Teleconference) • Orange County Children's Partnership Meeting (Pending Format)
7/20/2020	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting (Pending Format)
7/21/2020	• North Orange County Senior Collaborative All Members Meeting (Virtual Meeting) • Placentia Community Collaborative Meeting (Virtual Meeting)
7/22/2020	• Orange County Strategic Plan on Aging (Pending Format)
7/23/2020	• Orange County Care Coordination for Kids Meeting (Pending Format)
7/24/2020	• Orange County Veterans and Military Families Collaborative, Health and Wellness Subcommittee Meeting (Pending Format)
7/28/2020	• Orange County Senior Roundtable (Pending Format)

As of June 24, 2020, CalOptima expects to organize or convene five community stakeholder events, meetings or presentations through virtual meetings or teleconferences during June and July.

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	**Events/Meetings/Presentations**
6/17/2020	• Community-Based Organization Presentation to collaborative members of Move More, Eat Healthy Committee — Topic: Medi-Cal in Orange County (Virtual Presentation)
6/18/2020	• Health Network Forum (Virtual Meeting)
6/23/2020	• Community-Based Organization Presentation to Boat People SOS-CA staff — Topic: Medi-Cal in Orange County (Virtual Presentation)

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6/24/2020	• CalOptima Cafecito Meeting (Virtual Meeting)

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
6/15/2020	• Community-Based Organization Presentation to members of Cal State Fullerton Center for Healthy Neighborhoods — Topic: Medi-Cal in Orange County (Virtual Presentation)

CalOptima provided two endorsements consistent with CalOptima Policy AA. 1214: Guidelines for Endorsements by CalOptima, for Letters of Support and Use of CalOptima Name and Logo, since the last reporting period (e.g., letters of support, program/public activity events with support or use of name/logo).

1. Provided a Letter of Support to Orange County Health Care Agency for the Community Advancement for the Centers for Disease Control and Prevention Comprehensive Suicide Prevention Plan.

2. Provided a Letter of Support to Mind OC requesting use of CARES funding to enhance and expand the vital Orange County mental health system.

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CalOptima Board of Directors
Community Activities

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public activities, which meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in several community meetings, including coalitions, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima is following all local, state and federal guidelines in an effort to prevent the spread of COVID-19 in our workplace and the community.

In response to the COVID-19, CalOptima is transitioning how we engage with our community partners and will not be attending in-person Community Collaborative meetings. In addition, most community events and resource fairs have been cancelled, postponed or have transitioned to an alternate platform in response to COVID-19. CalOptima has updated our participation in Community Collaborative meetings and community events. With respect to events that have been cancelled or postponed due to COVID-19 in which sponsorship or fees have already been paid, event organizers will be provided the option to refund previously pre-paid participation fees or apply paid sponsorship fees to any future events, provided the future event(s) meet the criteria set forth in Policy AA.1123 and meets eligibility requirements indicated by Board of Directors.

+ Exhibitor/Attendee
++ Meeting Attendee

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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.

August

Date and Time	Event Title	Event Type/Audience	Staff/ Financial Participation	Location
Tuesday, 8/4 9:30–11 a.m. (Virtual format)	++ Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 8/5 9 – 10:30 a.m. (Virtual format)	++ OC Aging Services Collaborative General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 8/5 10 a.m.–12 p.m. (Virtual format)	++ Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Community Center 250 E. Center St. Anaheim
Wednesday, 8/5 10:30 a.m.–12 p.m. (Virtual format)	++ Orange County Healthy Aging Initiative/OCSPA Healthcare Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 1515 McCabe Way Irvine
Thursday, 8/6 9–11 a.m. (Virtual format)	++ Continuum of Care Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 8/6 11 a.m.–1 p.m. (Virtual format)	++ Garden Grove Community Collaborative Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Courtyard Center 12732 Main St. Garden Grove
Monday, 8/10 1–2:30 p.m. (Virtual format)	++ Orange County Veterans and Military Families Collaborative - Children and Family Working Group	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana

+ Exhibitor/Attendee
++ Meeting Attendee

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Monday, 8/10 2:30–3:30 p.m. (Virtual format)	++ Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 8/11 10–11:30 p.m. (Virtual format)	++ Orange County Cancer Coalition Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Susan G. Komen OC 2817 McGaw Ave. Irvine
Tuesday, 8/11 3:30–5:30 p.m. (Virtual format)	++ San Clemente Youth Wellness and Prevention Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	189 Avenida La Cuesta San Clemente
Wednesday, 8/12 12–1:30 p.m. (Pending)	++ Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 8/12 3:30–4:30 p.m. (Conference call)	++ Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Thursday, 8/13 11:30 a.m.–12:30 p.m. (Virtual format)	++ Garden Grove Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Garden Grove Community Center 11300 Stanford Ave. Garden Grove
Thursday, 8/13 12:30–1:30 p.m. (Conference call)	++ Kid Healthy Community Advisory Committee Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	OneOC Building C 1901 E. Fourth St. Santa Ana
Monday, 8/17 1–4 p.m. (Pending)	++ OCHCA Mental Health Services Act Steering Committee	++ OCHCA Mental Health Services Act Steering Committee	N/A	Delhi Community Center 505 E. Central Ave. Santa Ana
Wednesday, 8/19 9–10:30 a.m. (Conference call)	++ Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Monday, 8/24 9–11 a.m. (Virtual format)	++ Community Health Research and Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Monday, 8/24 12:30–1:30 p.m. (Virtual format)	++ Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Thursday, 8/27 1:30–3:30 p.m. (Virtual format)	++ Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	CHOC Centrum Building 1120 W. La Veta Orange