NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

MARCH 3, 2022
2:00 P.M.

505 CITY PARKWAY WEST, SUITE 108
ORANGE, CALIFORNIA 92868

BOARD OF DIRECTORS

Supervisor Andrew Do, Chair	Clayton Corwin, Vice Chair
Isabel Becerra	Supervisor Doug Chaffee
Clayton Chau, M.D.	Blair Contratto
José Mayorga, M.D.	J. Scott Schoeffel
Nancy Shivers, R.N.	Trieu Tran, M.D.

Supervisor Katrina Foley, Alternate

CHIEF EXECUTIVE OFFICER (INTERIM)	OUTSIDE GENERAL COUNSEL	CLERK OF THE BOARD
Michael Hunn	James Novello Kennaday Leavitt	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 identifying the item 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 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 or +1 (562) 247-8422 and Access Code: 438-670-667 or**
2) **Participate via Webinar at https://attendee.gotowebinar.com/register/1599949268904540172 rather than attending in person. Webinar instructions are provided below.**

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report

2. Medi-Cal Rx Update

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
3. Minutes
   a. Approve Minutes of the February 3, 2022 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the November 18, 2021 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee

4. Appointment to the CalOptima Board of Directors' Investment Advisory Committee

5. Approve Authorization of Capital and Operating Expenditures for Various Facilities Items

6. Revisions to CalOptima's Fiscal Year 2021-22 Multipurpose Senior Services Program Operating Budget

7. Approve Modifications to Policy GA.5004: Travel Policy

8. Approve Modifications to Policy GA.3301: Capitalization Policy

9. Adopt Resolution No. 22-0303-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

10. Ratify an Amendment to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services (DHCS) Related to Rate Changes

11. Authorize and Direct Execution of Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services Related to Rate Changes

12. Ratify Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Calendar Year (CY) 2022 Risk Mitigation Contract Amendment, CY 2021 COVID Vaccine Incentive Program Contract Amendment and 2022 Community Supports Contract Amendment

13. Authorize an Amendment to Contract MS-21-22-41 with the California Department of Aging to Expand Member Slots in the Multipurpose Senior Services Program

14. Authorize Extending Contract with Health Management Associates for Consulting Services to Assist with Preparation and Remediation for the Department of Health Care Services (DHCS) Routine Medical Audit Scheduled for January 2022 and Authorize Expenditures from Existing Reserves for such Services

15. Approve Modifications to CalOptima Policy GG.1665 Telehealth and Other Technology-Enabled Services

16. Approve New CalOptima Policy GG.1666 PP Mobile Texting

17. Approve CalOptima Policies GG.1105: Coverage of Organ and Tissue Transplants and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization

18. Approve Proposed Changes to the CalOptima Medical Affairs Policies related CalAIM Enhanced Care Management and Community Supports

19. Receive and File:
    a. January 2022 Financial Summary
    b. Compliance Report
    c. Federal and State Legislative Advocates Reports
    d. CalOptima Community Outreach and Program Summary

REPORTS/DISCUSSION ITEMS

20. Adopt Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule; Authorize the Interim Chief Executive Officer to Implement Cost-of-Living Adjustments and Changes to Executive Level Job Titles, and Appropriation of Funds and Authorization of Unbudgeted Expenditures

21. Authorize CalFresh Outreach Strategy to Enroll Eligible CalOptima Members into the CalFresh Program to Address Food Insecurity

22. Approve Amendment VIII to the Kaiser Foundation Health Plan Inc. Contract for Health Care Services, for the Medi-Cal COVID-19 Vaccination Incentive Program

23. Authorize Contract with Moss Adams LLP for Independent Financial Auditing Services

24. Authorizing Insurance Policy Procurements and Renewals for Policy Year 2022-23

25. Authorize Formation of the CalOptima Foundation

ADVISORY COMMITTEE UPDATES

26. Special Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee Updates

CLOSED SESSION

CS-1. Pursuant to Government Code Section 54957(b)(1): PERFORMANCE REVIEW OF INTERIM CEO MICHAEL HUNN

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

HOW TO JOIN

1. Please register for Regular Meeting of the CalOptima Board of Directors on March 3, 2022 2:00 PM PDT at: https://attendee.gotowebinar.com/register/1599949268904540172

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:

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   United States: +1 (562) 247-8422

   Access Code: 438-670-667

   Audio PIN: Shown after joining the webinar

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MEMORANDUM

DATE:	February 24, 2022
TO:	CalOptima Board of Directors
FROM:	Michael Hunn, Chief Executive Officer (Interim)
SUBJECT:	CEO Report — March 3, 2022, 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

a. Department of Health Care Services (DHCS) Annual Medi-Cal Audit Concludes

The DHCS annual routine medical audit of CalOptima's Medi-Cal plan concluded on February 4th, 2022. I would like to acknowledge the entire team and the Office of Compliance for their leadership. DHCS auditors provided positive feedback and were complimentary, noting that CalOptima was well-organized. We have begun to proactively address areas of opportunity found both before and during the audit. DHCS acknowledged the active remediation efforts, and while they do not absolve CalOptima of 'potential' findings, they do indicate to DHCS that the issues are being addressed. A formal exit conference will be held during the second week in April. DHCS noted preliminary areas for improvement, including:

- Prior authorization, appeals, post-stabilization authorization, quality of care grievances, non-emergency medical transportation approvals, and call inquiry documentation.
- Delegation oversight of Kaiser (prior authorizations and appeals), and Kaiser's call inquiry documentation and quality of service grievance timeliness.
- Need for better reporting/escalating issues that potentially impact quality of care.

b. Enrollment of Eligible Members in CalFresh

CalOptima is collaborating with the County of Orange Social Services Agency (SSA) to raise awareness about CalFresh as part of our effort to address social determinants of health. SSA reports that there are approximately 344,000 CalOptima members (approximately 259,000 households) who are potentially eligible to enroll and benefit from this program. Staff is bringing a funding request to the March Board meeting that will support a targeted outreach campaign that includes a variety of tactics, including direct member communications, a toolkit for providers and community-based organizations, community events, media outreach and advertising. The goal is increase CalFresh enrollment among CalOptima members.

c. Orange County Point-in-Time Count Helps Determine Services for Homelessness

The Point-in-Time Count is a biennial count and survey of people experiencing homelessness. The dates this year were Monday, February 21, through Thursday, February 24. The count provides vital information that helps the County of Orange and the Orange County Continuum of Care better understand homelessness in the community and guides the response to homelessness in Orange County. I am proud to say that several teams of CalOptima employees participated in the Point in Time count, including myself, the CMO, COO, CFO and COS. Once the count is finalized by the County, we will share the results with the Board and make recommendations on

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how CalOptima can serve this vulnerable population. A preliminary review of data of CalOptima members estimates that there may be up to 10,756 individuals who are potentially experiencing homelessness based on claim codes or addresses that indicate they have no permanent shelter. We will share more information on this issue with the Board in future reports.

d. Medi-Cal Rx Implementation Continued Issues for Providers

In February, DHCS hosted a Medi-Cal Rx webinar with managed care plans to discuss implementation issues. CalOptima's Customer Service department has received 1,790 member and provider inquiries since January 3 - February 18. Magellan is holding virtual office hours daily at noon on Zoom, where providers can report issues with the Medi-Cal Rx through a Secured Provider Portal. Magellan and DHCS are continuing to address issues as they arise and triage the requests, noting that most calls are related to prior authorizations. Although most pharmacy benefits are now carved out of CalOptima, we are committed to supporting our Medi-Cal members as much as possible through what has become a challenging implementation by the State.

e. Proposed Legislation - Impacts to CalOptima

January 31, 2022, was the deadline for state legislation introduced in 2021 to pass their house of origin. Ahead of this date, there were developments on two bills with potentially significant impacts to CalOptima:

AB 1355: Medi-Cal Independent Medical Review (IMR) System passed the Assembly floor and was referred to the Senate.

- Summary: Effective January 1, 2023, the bill would require DHCS to establish an IMR system for Medi-Cal plans without a Knox-Keene license (KKL). The new IMR process would closely mirror the Department of Managed Health Care IMR process for health plans with a KKL.
- Potential Impact: CalOptima Medi-Cal members would have access to an additional appeal process administered by DHCS. Staff would need to incorporate a new IMR process into GARS workflows.

Kaiser Permanente's Direct Contract with the State of California

Trailer bill legislation has been introduced to authorize DHCS to contract with an "Alternative Health Care Service Plan (AHCSP)," of which Kaiser is the only one in the State. Kaiser currently cares for 54,000 members in a fully delegated contract with CalOptima.

Per the trailer bill, AHCSP is a nonprofit health care service plan with at least four million enrollees statewide, owns or operates pharmacies, and provides professional medical services to enrollees in specific geographic regions through an exclusive contract with a single medical group in each specific geographic region in which it is licensed.

CalOptima's position is as follows:

While we respect our Kaiser colleagues and caregivers and recognize the quality care they provide, CalOptima is disappointed in the state's proposal to directly contract with Kaiser Permanente through a no-bid process lacking transparency. Of particular concern:

- The direct contract with the state creates a two-tiered public health system. Tier 1 is run by a private 'exclusive' plan that "cherry picks" the members they enroll, opening and closing enrollment based on business goals. Tier 2 is the public and community

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health system through CalOptima that accepts all eligible members at any time without barriers.

- Our doctors, hospitals, community clinics, and other provider partners serve ALL Medi-Cal members in Orange County, including the most underserved and under-resourced members, by addressing medical and social determinants of health. Kaiser's exclusive enrollment policy that allows them to serve healthier members should not be rewarded with equal reimbursement. The high-risk members will need to be cared for by the community and safety net physicians, thereby destabilizing these providers. Kaiser's ability to cherry pick puts our safety net providers at risk and is detrimental to the public's health.
- CalOptima members have broad choice of providers across the entire County and can find access in every zip code. Kaiser's delivery system limits choice by both location and by number of providers in Orange County.

f. CalOptima Joins State Budget Request for Data Sharing and Infrastructure

With a coalition of Medi-Cal plans, provider associations, and Orange County community clinics and health information exchanges, CalOptima has signed onto a letter requesting the addition of $100 million in the Fiscal Year 2022–23 state budget to accelerate Medi-Cal provider data sharing and infrastructure development. In alignment with CalOptima's Legislative Platform, this funding would help support the agency's successful implementation of California Advancing and Innovating Medi-Cal (CalAIM). Specifically, the funds could be used for performance payments for Medi-Cal providers to join and share data with health information organizations (HIOs), and for HIOs to build and maintain clinical data infrastructure.

g. Medi-Cal to Cover At-Home COVID-19 Tests Obtained at Pharmacies

On February 1, Medi-Cal started covering at-home COVID-19 tests obtained at pharmacies enrolled as Medi-Cal providers. The tests will be billed and reimbursed as a pharmacy-billed medical supply benefit through Medi-Cal Rx. At-home COVID-19 tests dispensed from a pharmacy and covered by Medi-Cal Rx will require a prescription, which can be provided by a pharmacist at the time the tests are dispensed. To match the federal requirement for private health plans to cover at-home COVID-19 tests, DHCS has proposed a limit of eight tests per beneficiary per month.

h. COVID-19 Clinics Continue as Percentage of Vaccinated Members Climbs

As of February 21, CalOptima reached a key milestone as 60% of all members ages 5 and up are now vaccinated. At six upcoming vaccine clinics in March and April, CalOptima staff will continue to distribute $25 Member Health Rewards to eligible members and SSA representatives will be facilitating enrollment in CalFresh for those who qualify. Future clinics are March 12, March 19, March 26, April 9, April 16 and April 23.

i. Monthly CalTeam Meetings Encourage Dialogue Between Staff and Leaders

Beginning in January, CalOptima launched a new monthly virtual meeting format for all staff called CalTeam. These meetings provide an opportunity for staff to hear from leaders about important topics and engage with them in a virtual dialogue through a live Q&A. More than 900 staff participated in the recent February 16 meeting. Recorded broadcasts are accessible after the meeting as are answers to live questions not addressed during the one-hour meeting.

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j. CalOptima Gains Media Coverage

- On February 7, Orange County Breeze ran an article about CalOptima's $1 million grant to Be Well OC for improved intake and admissions coordination services.
- On February 16, Spectrum News aired a news segment highlighting CalOptima's mobile mammography clinics, which are based on a Population Needs Assessment that identified a low incidence of breast cancer screenings in among Korean and Chinese members.
- On February 19, the KABC 5 p.m. newscast ran a brief story about CalOptima's vaccine clinic at Second Baptist Church in Santa Ana that same day. In total, 225 people got a vaccine at the event. *(Story starts at 5:11:30 at the link.)*

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Medi-Cal Pharmacy Carve Out (Medi-Cal Rx) Update

Board of Directors Meeting

March 3, 2022

Michael Hunn, Chief Executive Officer (Interim)

Kris Gericke, Pharm.D., Pharmacy Director

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Medi-Cal Rx

- Executive Order (EO) N-01-19: Effective January 1, 2021, Department of Health Care Services (DHCS) is "carving out" part of the pharmacy benefit from managed care plans and moving it to a fee-for-service (FFS) program
  - November 2020: postponed start to April 1, 2021
  - February 2021: postponed start to January 1, 2022
- "Medi-Cal Rx" is the name DHCS has given to this new system of how Medi-Cal pharmacy benefits will be administered
- DHCS selected a Pharmacy Benefit Manager (PBM) vendor to administer the new pharmacy program: Magellan Rx

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Medi-Cal Rx (cont.)

- Medi-Cal activities covered by Magellan Rx
  - Claims processing for all pharmacy services billed by pharmacies
  - Pharmacy Prior Authorizations (PAs)
  - Pharmacy-related Customer Service and grievances (beneficiaries and providers)
  - Health plan coordination activities (Magellan Rx liaison)

Medi-Cal Rx Go-Live Concerns

- There have been numerous eligibility issues
  - Members showing ineligible when they are eligible
  - Magellan system showing other primary insurance that is not accurate
- The transition period did not always function as intended
  - Certain drugs reject even though they are continuation of care or have an approved PA
  - Claims reject if they exceed a maximum cost threshold, which requires submission of an additional PA
  - Claim reject messages are often unclear
  - Pharmacies are being reimbursed below their cost in some cases

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Medi-Cal Rx Go-Live Concerns (cont.)

- Magellan Rx Call Center
  - Call wait times have been very long for providers and members (at times exceeding seven hours)
  - When using the call back option, often no return call is received
  - There are reports of callers being on hold for several hours and then the calls are disconnected
  - At times, Magellan Rx staff provide misinformation or could not help resolve issues
  - Magellan Rx staff are not authorized to provide any claim overrides or escalate urgent PAs

Medi-Cal Rx Go-Live Concerns (cont.)

- PA process
  - Significant delays in processing PAs (over 7 days instead of within 24 hours)
  - When submitting PAs through CoverMyMeds or fax, providers receive a denial without appeal rights in some cases
  - Often providers cannot tell why a PA has been denied
- Appeals process
  - Members cannot appeal PA denials; they can only file State Fair Hearings
  - Providers cannot appeal PA denials by phone; they can only submit appeals via fax, the Magellan Rx portal or U.S. mail
  - Magellan has 60 days to process an appeal; there is no shorter review timeframe for expedited appeals

Medi-Cal Rx Go-Live Concerns (cont.)

- Whole-Child Model (WCM)
  - Standard PBM PA criteria and processes do not adequately address the unique needs of children with serious medical conditions
  - Cases of PA denials where EPSDT medical necessity criteria were not taken into account
  - Limited state CDL requires a PA for medications for which CalOptima did not require authorization
  - CDL is missing liquid formulations and other medications common for pediatric use
  - Medically necessary medications and supplies are denied as not covered

Medi-Cal Rx Go-Live Concerns (cont.)

- Ongoing issues
  - PA volume and calls will increase when the temporary claims rejection edits end on April 30, 2022 and when the grandfathering transition period ends on June 30, 2022
  - Additional changes are needed for the CDL to improve access
- Magellan Rx solutions to improve performance
  - Magellan Rx is hiring additional staff for their Customer Service Center and for PA processing
  - Temporarily removed many claims rejection edits until April 30, 2022
  - Magellan Rx started daily office hour meetings for providers and biweekly meetings with managed care plans

CalOptima Assistance

- On February 8, CalOptima notified providers on how they can contact CalOptima Pharmacy Management directly for assistance with medication access issues
- CalOptima Pharmacy Management staff have been contacting providers, pharmacies and/or the Magellan Rx liaison to help resolve issues
  - Since January 1, 2022, CalOptima Customer Service has received more than 1,700 member calls related to medication issues
  - CalOptima Pharmacy Management staff review Customer Service calls daily and determine if additional assistance may be required

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Advocacy Efforts

- CalOptima continues to collaborate with state trade associations, including Local Health Plans of California and California Association of Health Plans
- On December 13, 2021, CalOptima Interim CEO Michael Hunn met with California Health and Human Services Secretary Dr. Mark Ghaly to reiterate outstanding priority issues
- Government Affairs met with DHCS staff on December 17, 2021, to discuss specific member needs not being addressed
- CalOptima, CHOC and UCI staff met with Magellan and DHCS executives on February 10, 2022, to discuss ongoing concerns

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Our Mission

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

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

February 3, 2022

The Regular Meeting of the CalOptima Board of Directors was held on February 3, 2022 at CalOptima, 505 City Parkway West, Orange, California. The meeting was held via teleconference (Go-to-Webinar) in light of the COVID-19 public health emergency and of Assembly Bill (AB) 361 (Chaptered September 16, 2021), which allows for temporary relaxation of certain Brown Act requirements related to teleconferenced meetings. Chairman Andrew Do called the meeting to order at 2:02 p.m., and Director Becerra led the Pledge of Allegiance.

ROLL CALL

Members Present: Supervisor Andrew Do, Chairman; Clayton Corwin, Vice Chair; Isabel Becerra; Supervisor Doug Chaffee; Clayton Chau, M.D. (non-voting); Blair Contratto; José Mayorga, M.D.; Scott Schoeffel; Nancy Shivers, Trieu Tran, M.D.
(The following Board Members participated remotely: Supervisor Chaffee, Director Schoeffel, Director Shivers, and Director Tran)

Members Absent: None

Others Present: Michael Hunn, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Yunkyung Kim, Chief Operating Officer; Nancy Huang, Chief Financial Officer; Richard Helmer, M.D., Interim Chief Medical Officer; Sharon Dwiers, Clerk of the Board

PRESENTATIONS/INTRODUCTIONS

The Board thanked the Utilization Management (UM) team and volunteers for their tireless and quick work to resolve the backlog of UM authorizations for CalOptima members.

Michael Hunn, Interim Chief Executive Officer, noted that the UM team and volunteers had cleared over 15,200 UM authorizations from December 13, 2021, and as January 22, 2022 all UM authorizations are up-to-date. Mr. Hunn also thanked staff for completing the work in such a short timeframe.

MANAGEMENT REPORTS

1. Chief Executive Officer Report

Mr. Hunn highlighted several items from his CEO Report, including announcing that Richard Pitts, D.O., Ph.D., will join CalOptima on February 7, 2022, as the new Chief Medical Officer. Mr. Hunn also provided an update on the Medi-Cal Rx program rollout. Mr. Hunn noted that staff will be tracking the number of calls being received and types of issues members are experiencing. CalOptima is working closely with the Department of Health Care Services (DHCS) and the leadership at the state level and will provide feedback on the agency's experience during the rollout.

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CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the December 20, 2021 Special Meeting of the CalOptima Board of Directors

3. Adopt Board Resolution No. 22-0203-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

4. Authorization to Enter into Negotiations with the County of Orange to Modify and Extend the Current License Agreement for Use of Space at the County Community Service Center Annex
Director Schoeffel did not participate in this item due to potential conflicts of interest.

5. Authorize Modification to the Extension of the Contract with Miller Geer & Associates for External Communications Support Services

6. Authorize Actions Related to American Family Housing Casa Paloma Care Coordination

7. Authorization to Execute a Contract Amendment for Updated Rates Related to the CalOptima Multipurpose Senior Services Program (MSSP) Non-Medical Ancillary Fee-For-Service Contract with Kenady Corporation, dba LifeSpring Nutrition for MSSP Home Delivered Meals

8. Authorize Amendment to Contract with Kenady Corporation, dba LifeSpring Nutrition, to Support CalOptima Program of All-Inclusive Care for the Elderly (PACE) Home-Delivered Meals

9. Approval of Modifications to CalOptima Customer Service Policies: DD.2001 and DD. 2002

10. Approve Changes to CalOptima Provider Network Policies

11. Approve Modifications to CalOptima Policy CMC. 2001: Primary Care Engagement and Clinical Documentation Integrity Program for CalOptima Community Network Contracted Providers to Require a Medicare Annual Wellness Visit to be Completed

12. Authorize an Amendment to the Veyo LLC Fee-For-Service Ancillary Services Contract to Increase Rates for Select Services Provided to Medi-Cal, OneCare, and OneCare Connect Members

13. Authorize Allocation of Intergovernmental Transfer (IGT) 10 Funds to the Coronavirus (COVID-19) Member Vaccination Incentive Program (VIP)
Director Schoeffel did not participate in this item due to potential conflicts of interest.

14. Receive and File:
   a. November and December Financial Summary
   b. Compliance Report
   c. Federal and State Legislative Advocates Reports
   d. CalOptima Community Outreach and Program Summary

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Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 8-0-0 (except as noted); Director Schoeffel absent on Agenda items 4 and 13)***

Chairman Do announced for the record that he was abstaining on Agenda Items 15 through 19 and Agenda Item 21 due to conflicts of interest related to campaign contributions under the Levine Act and passed the gavel to Vice Chair Corwin.

REPORTS/DISCUSSION ITEMS

15. Request to Ratify and Extend the Use of Temporary Utilization Management Protocol for Referrals to University of California, Irvine Specialist Physicians through 2/28/2022

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Ratified past approval and authorized continuation of automatic approval of all CalOptima Direct (COD) and CalOptima Community Network (CCN) care referred to University of California, Irvine specialty physicians as support for a temporary solution for Prior Authorization timeliness and to increase access to care for requests received by CalOptima prior to February 28, 2022. The following services are excluded from this streamlined process: ●Elective surgeries; ●Kidney transplants; and ●Pediatric Services (to identify CCS-paneled provider reviews); and 2.) Authorized unbudgeted expenditures in an amount up to $376,000 from existing reserves to support the increased medical expenses associated with the temporary approval process change. (Motion carried 6-0-1 (except those noted); Chairman abstained; Directors Mayorga and Schoeffel absent)***

16. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-For-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Tran did not participate in this item due to his role as a Physician Specialist serving CalOptima members.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Ratified:1.).Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted Medi-Cal***

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fee-for-service (FFS) primary care, specialist and ancillary providers, for certain medically necessary services provided to CalOptima Community Network (CCN) and CalOptima Direct (COD) Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; 2.) Extension of a temporary, short-term supplemental payment increase of 5% from FY 2021-22 original budgeted funding levels, for compliant, contracted Medi-Cal FFS behavioral health providers for services provided to all CalOptima Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; and 3.) Use of unbudgeted expenditures up to $8.3 million from existing reserves to provide funding for the recommended supplemental payment increases. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Mayorga, Schoeffel and Tran absent)

17. Ratify Extension of a Temporary, Short Term Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct-Administrative Medi-Cal Fee-For-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Networks and CalOptima Direct-Administrative Medi-Cal Members

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Becerra did not participate due to her role as Chief Executive Officer of the Coalition of Orange County Community Health Centers. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Ratified: 1.) Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, contracted CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Community Health Centers, for certain medically necessary services provided to CalOptima CCN and COD-A Medi-Cal members on dates of service January 1, 2022, through June 30, 2022; and 2.) Use of unbudgeted expenditures up to $240,000 from existing reserves to provide funding for the recommended supplemental payment increases. (Motion carried 5-0-1 (except as noted) Chairman Do abstained; Directors Becerra, Mayorga, and Schoeffel absent)***

18. Ratify Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-For-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct – Administrative Medi-Cal Members.

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest.

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Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors Ratified: 1.) Extension of a temporary, short-term supplemental payment increase of 5% from Fiscal Year (FY) 2021-22 original budgeted funding levels, for compliant, CalOptima Community Network (CCN) and CalOptima Direct-Administrative (COD-A) Medi-Cal Fee-for-Service (FFS) Hospitals, for certain medically necessary services provided to CCN and COD-A Medi-Cal members for dates of service January 1, 2022, through June 30, 2022; and 2.) Use of unbudgeted expenditures up to $5.5 million from existing reserves to provide funding for the supplemental payment increase to Medi-Cal FFS hospitals (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Mayorga and Schoeffel absent)***

19. Authorize Amendments to the CalOptima Community Network Professional Services Contracts to Add OneCare as a Covered CalOptima Program

Chairman Do did not participate in the discussion and vote on this item due to conflicts of interest under the Levine Act. Director Mayorga did not participate in this item due to his role as Executive Director at UC Irvine Health. Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Tran did not participate in this item due to his role as a Physician Specialist serving CalOptima members.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Authorized an amendment to the CalOptima Community Network (CCN) Professional Services Contracts to add OneCare as a covered CalOptima program, effective January 1, 2023. (Motion carried 5-0-1 (except as noted); Chairman Do abstained; Directors Mayorga, Schoeffel and Tran absent)***

The Board of Directors heard Agenda Item 21 immediately after Agenda Item 19.

21. Authorize Appropriation of Funds, Unbudgeted Expenditures and a Grant Agreement with Mind OC for Intake and Admissions Coordination Services at the Be Well OC Wellness Center Orange Campus

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

Action: ***On motion of Director Shivers, seconded and carried, the Board of Directors: 1.) Authorized a Grant Agreement with Mind OC for intake and admissions coordination services at the Be Well OC Wellness Center Orange Campus; 2.) Appropriated funds and authorized unbudgeted expenditures in the amount of up to $1.0 million from existing reserves to fund the Grant Agreement with Mind OC; 3.) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 4.) Authorized the Chief Executive Officer to execute a two-year and eight month Grant Agreement with Mind OC to provide up to $1.0 million to***

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allow for enhanced intake and admissions coordination services provided to CalOptima Medi-Cal members at the Be Well OC Wellness Center Orange Campus. (Motion carried 7-0-1 (except as noted); Chairman Do abstained; Director Schoeffel absent)

Vice Chair Corwin passed the gavel back to Chairman Do.

20. Ratify the Contract with Illumination Foundation for the Provision of Accompaniment Services for Enhanced Care Management (ECM) Under the California Advancing and Innovating Medi-Cal Program (CalAIM); Authorize an Amendment to this Contract; and Authorize Contracts with Other Qualified Accompaniment Services Providers Using the Ancillary Services Contract for Non-Medical Providers Template

Action: ***On motion of Director Contratto, seconded and carried, the Board of Directors: 1.) Ratified the Ancillary Services Contract for Non-Medical Providers with Illumination Foundation for the provision of accompaniment services for Enhanced Care Management (ECM) to eligible CalOptima Direct (COD) members under the California Advancing and Innovating Medi-Cal program (CalAIM), effective January 1, 2022; 2.) Authorized the Chief Executive Officer, with the assistance of Legal Counsel, to amend the Illumination Foundation Ancillary Services Contract, effective January 1, 2022, to be consistent with the Ancillary Services Contract for Non-Medical Provider template; and 3.) Authorized the CEO to contract with qualified accompaniment providers, utilizing the Ancillary Services Contract for Non-Medical Provider template, for the provision of accompaniment services for ECM to eligible COD members. (Motion carried 9-0-0)***

22.Authorize Amendments to the Children's Hospital of Orange County and CHOC Physician Network Contracts for Health Care Services Reflecting Language Regarding its Pediatric Member Population
Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors Authorized the Chief Executive Officer (CEO) to amend the capitated/delegated Children's Hospital of Orange County and CHOC Physician Network Contracts (CHOC) for Health Care Services to add language reflecting the definition of CHOC's member population. (Motion carried 8-0-0; Director Schoeffel absent)***

23. Authorize New and Amended Contracts for ARTA Western California Inc., Monarch HealthCare A Medical Group Inc., and Talbert Medical Group P.C. to Reflect Name Changes
Director Schoeffel did not participate in this item due to potential conflicts of interest. Director Shivers did not participate in this item due to her role as Case Manager at Optum.

Action: ***On motion of Supervisor Chaffee, seconded and carried, the Board of Directors Authorized the Chief Executive Officer, to execute: 1.) New Shared-Risk Group (SRG) Medi-Cal and OneCare Connect health***

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network contracts for ARTA Western California Inc. and Talbert Medical Group P.C. to reflect a name change to ARTA Western California Inc. dba Optum, and Talbert Medical Group P.C. dba Optum, to be effective March 1, 2022; and 2.) Amendments to the OneCare Shared-Risk Group (SRG) contracts for ARTA Western California Inc., Monarch HealthCare, A Medical Group Inc. and Talbert Medical Group P.C. contracts, to reflect a name change to ARTA Western California Inc. dba Optum, Monarch HealthCare, A Medical Group Inc. dba Optum, and Talbert Medical Group P.C. dba Optum, to be effective March 1, 2022 (Motion carried 7-0-0; Directors Schoeffel and Shivers absent)

24.Approve Amendment to Heritage Provider Network, Inc's .Medi-Cal Health Network Contract for Health Care Services to Specify Requirements and Responsibilities Related to CalOptima's Enhanced Care Management Services, effective January 1, 2022

Director Schoeffel did not participate in this item due to potential conflicts of interest.

Action: ***On motion of Vice Chair Corwin, seconded and carried, the Board of Directors Authorized the Chief Executive Officer to amend the Heritage Provider Network, Inc.'s Medi-Cal Health Network Contract for Health Care Services, effective January 1, 2022, to specify requirements and responsibilities related to CalOptima's Enhanced Care Management services for California Advancing and Innovating Medi-Cal. (Motion carried 8-0-0: Director Schoeffel absent)***

25. Adopt Resolutions to Authorize the Appointment of Retired Annuitants to the Positions of Interim Chief Medical Officer and Medical Director to Carry Out the Duties and Responsibilities of the Vacant Positions During a Public Health Emergency to Mitigate the Effects of the COVID-19 Pandemic and Prevent the Stoppage of Public Business

Action: ***On motion of Director Becerra, seconded and carried, the Board of Directors: 1.) Adopted Resolution No. 22-0203-02 continued appointment of a CalPERS retired annuitant in accordance with Government Code section 21221, subdivision (h) and Executive Order N-84-20 during a public health emergency to mitigate the effects of the COVID-19 pandemic, and certifying the nature of the employment of Dr. Donald Sharps; 2.) Authorized the CEO to continue to appoint Dr. Donald Sharps as an interim appointment retired annuitant to the vacant position of Medical Director beyond the work hour limitations as permitted by Executive Order N-84-20; 3.) Adopted Resolution No. 22-0203-03 authorizing the hiring of a CalPERS retired annuitant in accordance with Government Code section 21222, subdivision (h) and pursuant to Executive Order N-84-20 to the position of Interim Chief Medical Officer during a public health emergency to mitigate the effects of the COVID-19 pandemic, reappointment to the position of Medical Director thereafter during a public health emergency to***

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mitigate the effects of the COVID-19 pandemic, and certifying the nature of the employment of Dr. Richard Helmer; 4.) Authorized the CEO to approve and appoint Dr. Richard Helmer as an interim appointment retired annuitant to the vacant position of Interim Chief Medical Officer from December 22, 2021, to February 6, 2022, and reappoint Dr. Richard Helmer as an interim appointment and retired annuitant to the vacant position of Medical Director effective February 7, 2022; and 5.) Authorized the CEO, or his designee, to continue the current search for permanent Medical Directors. (Motion carried 9-0-0)

PUBLIC COMMENTS
There were no requests for public comment.

ADVISORY COMMITTEE UPDATES

26. Special Joint Meeting of the CalOptima Advisory Committees Update
Patty Mouton, OneCare Connect Member Advisory Committee (OCC MAC) Chair, provided an update on the OCC MAC's recent activities. She also announced the appointment of new OCC MAC member Nury Melara.

Christine Tolbert, Member Advisory Committee (MAC) Chair, provided an update on the MAC's recent activities and thanked Interim CEO Michael Hunn for his collaboration on items of interest to MAC members.

Junie Lazo-Pearson, Provider Advisory Committee (PAC) Chair, provided an update on the recent Special Joint meeting of the CalOptima Advisory Committees.

Chairman Do reordered the agenda to hear Board Member Comments and Board Committee Reports ahead of the Closed Session.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

The Board thanked CalOptima staff for all the work regarding the launch of the CalAIM initiatives and the collaboration with the County of Orange and the community providers and stakeholders.

CLOSED SESSION
CS-1. Pursuant to Government Code section 54957 (b)(1): Public Employee Discipline/Dismissal/Release

The Board adjourned to closed session at 3:19 p.m.

The Board returned to open session at 3:43 p.m.

Chairman Do noted for the record that the following Board Members were present after reconvening to open session: Directors Contratto, Becerra, Mayorga, and Chau, and Vice Chair Corwin, and myself.

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The Clerk read the following into the record;

The Board has approved the Closed Session item and the decision is entered into the written record.

ADJOURNMENT
Hearing no further business, Chairman Do adjourned the meeting at 3:44 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: March 3, 2022

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THE CLERK ENTERS A WRITTEN RECORD OF THE BOARD's CLOSED SESSION MEETING INTO THE MEETING RECORD.

CS-1 THE BOARD APPROVES AND AUTHORIZES THE CEO TO DISMISS THE FOLLOWING EMPLOYEES:

Title	Employee Number
Executive Administrative Services Manager	1103
Chief Counsel	1365
Deputy Chief Counsel	1143
Staff Attorney Sr	2186
Staff Attorney Sr	3367
Paralegal/Legal Secretary	2226
Staff Attorney	3758
Staff Attorney Sr	1436
Staff Attorney Sr	2229

VOTING MEMBERS:	**Y**	**N**	**Abstain**	
Do	(X)	( )	( )	
Corwin	(X)	( )	( )	
Chaffee	(X)	( )	( )	
Chau	(X)	( )	( )	
Schoeffel	( )	( )	( )	Not in attendance
Shivers	(X)	( )	( )	
Mayorga	(X)	( )	( )	
Contratto	(X)	( )	( )	

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Tran	(X)	( )	( )
Beccrra	(X)	( )	( )

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS'
FINANCE AND AUDIT COMMITTEE

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

November 18, 2021

A Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee was held on November 18, 2021, 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 Isabel Becerra called the meeting to order at 2:09 p.m. Director Corwin led the Pledge of Allegiance.

Members Present: Isabel Becerra, Chair; Clayton Corwin; Scott Schoeffel (all Members at teleconference locations)

Members Absent: None

Others Present: Michael Hunn, Interim Chief Executive Officer; Gary Crockett, Chief Counsel; Nancy Huang, Chief Financial Officer; Yunkyung, Kim, Chief Operating Officer; Emily Fonda, M.D., Chief Medical Officer; Carmen Dobry, Executive Director of Compliance; Sharon Dwiers, Clerk of the Board

Chair Becerra announced that due to vacant seat on the Finance and Audit Committee a quorum constitutes as 3 votes and if a member has a conflict on an item, we will not have a voting quorum. Due to the importance of the Report Items, Chair Becerra has asked staff to provide informational updates on any items that are not able to meet a quorum.

MANAGEMENT REPORTS
1. Chief Financial Officer Report
Nancy Huang, Chief Financial Officer, announced the promotion of Eric Rustad to Executive Director, Finance. She noted that Mr. Rustad has been with CalOptima for almost 10 years and will continue to lead the financial analysis team. Ms. Huang congratulated Mr. Rustad on his promotion.

Ms. Huang reported that CalOptima had received the draft rates for Calendar Year 2022 in September 2021 from the Department of Health Care Services (DHCS) for the Medi-Cal-only and Coordinated Care Initiative (CCI) populations. She noted that while the rates are considered draft rates until the Centers for Medicare & Medicaid Services (CMS) approves, staff, during its preliminary review, found

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two areas where the draft rates show a favorable increase. One is for COVID-related treatment, testing, and mental health services costs, and the second is a higher trend assumption by the DHCS. Staff will provide an update after CMS approval and the rates are finalized.

Ms. Huang also provided an update on the Multi-Purpose Senior Select Program (MSSP) and noted that the California Department on Aging (CDA) has increased CalOptima's funding in an amount of $356,000 to support higher enrollment in CalOptima's MSSP Program.

INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Ms. Huang presented an overview of the Treasurer's Report for the period July 1, 2021, through September 30, 2021. As reported to the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.* and with CalOptima's Annual Investment Policy during that period.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

3. Approve the Minutes of the September 16, 2021, Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee and Receive and File Minutes of the July 26, 2021, Regular Meeting of the CalOptima Board of Directors' Investment Advisory Committee

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee approved the Consent Calendar as presented. (Motion carried 3-0-0)***

REPORTS

4. Consider Recommending Board of Directors Approval of Funding for an Independent Validation Audit as Required to Close out the CMS Program Audit for the OneCare and Once Care Connect Programs

Carmen Dobry, Executive Director, Compliance, introduced the item.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize unbudgeted expenditures in an amount up to $300,000 from existing reserves to fund an Independent Validation Audit as required under the CMS Medicare Advantage and Prescription Drug Program Audit ("CMS Audit") (Motion carried 3-0-0)***

5. Consider Recommending Board of Directors Approval of Modifications to Policy GA. 3400: Annual Investments

Ms. Huang introduced this item and provided a brief overview of changes to the Annual Investments policy.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors approve modifications to CalOptima Policy GA.3400: Annual Investments. (Motion carried 3-0-0)***

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6. Consider Recommending Board of Directors Approval of Modifications to CalOptima Policy FF.3001: Financial Reporting

Ms. Huang introduced the item and provided an overview of the changes to Policy FF.3001: Financial Reporting.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors approval of modifications to CalOptima Policy FF.3001: Financial Reporting. (Motion carried 3-0-0)***

7. Consider Recommending that the Board of Directors Authorize Unbudgeted Expenditures for Pace and Appropriate Funds in the CalOptima Fiscal Year 2021-22 Operating and Capital Budgets

Ms. Huang introduced this item and reviewed the expenditures for the PACE building, which included installation of new security cameras.

Director Corwin inquired if the $90,000 would be a recurring annual cost. Ms. Huang responded that staff would provide details on how much of the PACE building expenditures would be a recurring expense but estimated the cost to be about $45,000.00 annually. She noted that the recurring expenditures would be included in future fiscal year budgets.

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize unbudgeted: 1.) Capital expenditures and appropriate funds in an amount not to exceed $11,000 from existing reserves for Security Camera System Replacement at the PACE Center; and 2.) Operating expenditures and appropriate funds in an amount not to exceed $90,000 from existing reserves for the PACE program administrative expenses category under "PACE-Other Operating Expenses-Repairs & Maintenance" to support additional operating expenses through June 30, 2022. (Motion carried 3-0-0)***

8. Consider Recommending Board of Directors Approval of Extension of Reimbursement for Necessary Business Expenditures Incurred by Employees on Temporary Telework Due to the Coronavirus (COVID-19) Pandemic

Ms. Huang introduced the item, noting that this is an extension of the reimbursement of the flat rate of $45 per month for employees on temporary telework on a month-to-month basis, which is due to expire on December 31, 2021.

Action: ***On motion of Director Corwin, seconded and carried, the Committee recommended that the Board of Directors: 1.) Approve extension of reimbursement at a flat rate of $45 per month per temporary teleworker, continuing January 1, 2022, on a month-to-month basis through June 30, 2022 for necessary business expenditures incurred by regular full-time and part-time Employees on temporary telework due to the COVID-19 pandemic; 2.) Authorize the Chief Executive Officer (CEO) to extend the flat rate reimbursement on a month-to-month basis from January 1, 2022, through June 30, 2022 for employees on temporary telework; and 3.) Authorize and***

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appropriate unbudgeted expenditures in an amount up to $162,000 from existing reserves to fund the reimbursement for necessary business expenses of employees on temporary telework through June 30, 2022. (Motion carried 3-0-0)

For the record, Director Schoeffel is not participating in Agenda Items 9 through 13 due to potential conflicts of interest. Action on Agenda Items 9 through 13 will be continued to a future meeting.

As Chair Becerra noted at the top of the meeting, any Report Items where the Committee did not meet a quorum, would be presented as information items.

Yunkyung Kim, Chief Operating Officer, provided brief overviews of Agenda Items 9 through 13 for informational purposes and the Committee did not take action on these items.

9. Consider Recommending that the Board of Directors Authorize Extension of a Temporary, Short-Term, Supplemental Capitation Rate Increase for Contracted Medi-Cal Health Networks for COVID-Related Expenses for Services Provided to CalOptima Medi-Cal Members
This item was continued to a future meeting.

10. Consider Recommending that the Board of Directors Authorize Extension of a Temporary, Short-Term Supplemental Payment Increase for Certain Contracted CalOptima Fee-for-Service Providers for COVID-Related Expenses for Services Provided to CalOptima Community Network and CalOptima Direct Medi-Cal Members
This item was continued to a future meeting.

11. Consider Recommending Board of Directors Authorize Extension of a Temporary, Short-Term, Supplemental Payment Increase for Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Community Health Centers, for COVID-Related Expenses for Services Provided to CalOptima Community Networks and CalOptima Direct Medi-Cal Members
This item was continued to a future meeting.

12. Consider Recommending Board of Directors Authorize Extension of a Temporary, Short-Term, Supplemental Payment Increase for Certain Contracted CalOptima Community Network and CalOptima Direct Medi-Cal Fee-for-Service Hospitals, for COVID-Related Expenses for Services Provided to CalOptima Community Networks and CalOptima Direct Medi-Cal Members
This item was continued to a future meeting.

13. Consider Recommending that the Board of Directors Authorize Proposed Budget Reallocation of Fiscal Year 2021-22 Operating Budget Funds and Authorize Unbudgeted Expenditures and Appropriate Funds for Information Service Items
This item was continued to a future meeting.

INFORMATION ITEMS

The following Information Items were accepted as presented.

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14. September 2021 Financial Summary

15. CalOptima Information Security Update

16. Quarterly Operating and Capital Budget Update

17. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance Update
    b. Whole-Child Model Financial Report
    c. Health Homes Financial Report
    d. Reinsurance Report
    e. Health Network Financial Report
    f. Contingency Contract Report

COMMITTEE MEMBER COMMENTS

The Committee Members congratulated Mr. Rustad on his promotion and thanked staff for the work that went into preparing for this meeting.

ADJOURNMENT

Hearing no further business, Finance and Audit Committee Chair Becerra adjourned the meeting at 2:40 p.m.

/s/ Sharon Dwiers
Sharon Dwiers
Clerk of the Board

Approved: February 17, 2022

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
4. Appointment to the CalOptima Board of Directors' Investment Advisory Committee

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Approve the appointment of Annie Tran to the Board of Directors' Investment Advisory Committee (IAC) for a two-year term beginning March 4, 2022.

Background
At a Special Meeting of the CalOptima Board of Directors held on September 10, 1996, the Board authorized the creation of the CalOptima IAC, established qualifications for committee members, and directed staff to proceed with the recruitment of the volunteer members of the Committee. When creating the IAC, the Board specified that the Committee would consist of five (5) members; one (1) member would automatically serve by virtue of his or her position as CalOptima's Chief Financial Officer. The remaining four (4) members would be Orange County residents who possess experience in one (1) or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting. At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five (5) members to seven (7) members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion
As part of the process of filling the vacancies, staff conducted a recruitment process intended to solicit a diverse applicant pool of candidates. The recruitment included an announcement on the CalOptima website, referrals from current Board of Directors and IAC Members, and an advertisement in the local business journal. Staff received applications from two interested candidates and submitted them to the IAC Nominations Ad Hoc Committee for review and recommendation. This Ad Hoc Committee was comprised of IAC Members Moore and Huang and CalOptima staff.

Prior to conducting virtual interviews in early November 2021, the Ad Hoc Committee evaluated each of the applications submitted. The Ad Hoc Committee recommends one candidate to the IAC for consideration and approval.

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If appointed, the ad hoc committee believes that the candidate recommended for appointment will provide leadership and service to CalOptima's investment policy oversight through her participation as an IAC member. Annie Tran also has proven leadership and expertise in finance and accounting.

Ms. Tran is a CFA Chart-holder, holds an MBA in finance and a bachelor's degree in economics. Ms. Tran currently works for Charles Fish Investments as a Portfolio Manager. She has over 13 years of experience and previously worked as an Analyst for US Bank and an Investment Analyst intern for the City of Orange.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The individual recommended for CalOptima's IAC have extensive experience that meets or exceeds the specified qualifications for membership on the IAC.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachment
None

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Approve Authorization of Capital and Operating Expenditures for Various Facilities Items

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

1. Authorize unbudgeted expenditures and appropriate funds from existing reserves for the following operating expenditures through June 30, 2022:
    a. Up to $10,000 to Medi-Cal – Professional Fees to perform a building operating review;
    b. Up to $125,000 to Facilities – Other Operating Expenses for COVID-19 cleaning expenses; and
    c. Up to $80,000 to PACE – Other Operating Expenses for PACE renovation expenses.
2. Authorize unbudgeted expenditures and appropriate funds from existing reserves for the following capital expenditures:
    a. Up to $30,000 for 505 Building Improvements - New Roof Membrane Continuation; and
    b. Up to $170,000 to PACE – Equipment for PACE renovation expenses.
3. Authorize capital project expenditures of up to $50,000 for audio visual enhancement of conference rooms.

Background/Discussion

Recommended Action #1: Unbudgeted Operating Expenditures

Professional Services:

The CalOptima Fiscal Year (FY) 2021-22 Operating Budget was approved by the CalOptima Board of Directors on June 3, 2021. Staff included the best available information at the time of budgeting. In December 2021, Management recommended hiring a consultant to review 505 Building operations and procedures, including security, janitorial, HVAC, and short-term and long-term capital requirements. Staff estimates professional services expenses at $10,000 through June 30, 2022.

COVID-19 Cleaning:

With the ongoing COVID-19 public health emergency, particularly the impact of the Omicron variant, and keeping with the Centers for Disease Control and Prevention recommendations, Management requests additional funds to ensure compliance with sanitization services at the 505 Building. Staff estimates sanitization services at $125,000 through June 30, 2022.

PACE Renovation:

Management recommends modernization and renovation at the PACE Center. Staff estimates expenses at $80,000 for paint.

Recommended Action #2: Unbudgeted Capital Expenditures

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505 Building, New Roof Membrane:
At the October 7, 2021, meeting, the Board approved $275,000 from existing reserves for the capital project, 505 Building, New Roof Membrane. With this action, the total funds available is $375,000 for this project in the FY 2021-22 Capital Budget. This updated cost estimate was provided by a roofing consultant based on the revised scope of work which included removal and repair to the areas with moisture, removal and replacement of the walking pad, reinforcement of the roof under the rail track system and fluid applied coating over entire roof surface.

Upon completion of the Request for Proposal (RFP) process, the contract was awarded to Pacific Polymers Inc. All respondents' final bids were above the $375,000 available funding, with the lowest bid at $383,168. Staff requests additional funds up to $30,000 to address the shortfall in the contracted amount and to cover any contingency expenses from unforeseen field conditions.

PACE Renovation:
Due to new competition within the PACE market, Management recommends modernization, renovation, and upgrade to furniture at the PACE Center. Staff estimates expenses at $170,000 for furniture.

Recommended Action #3: Authorization of Capital Project
Audio Visual Enhancement to Conference Rooms:
The CalOptima Fiscal Year (FY) 2021-22 Capital Budget was approved by the CalOptima Board of Directors on June 3, 2021. The budget included a total capital amount of $478,000 for "Office Suite Renovation and Improvements: Building." Management recommends authorization to proceed with the capital project to upgrade technological capabilities in existing conference rooms at the 505 Building. Due to the ongoing pandemic, it is critical that CalOptima has the ability to hold remote teleconference public meetings for timely and transparent communications with our community partners and the public.

Staff conducted an informal bid process and will select a vendor to tentatively complete the installation by the end of March. The estimated one-time capital expenses for the new audio-visual system is approximately $50,000.

Fiscal Impact
Recommended Action #1: The recommended action is unbudgeted. An allocation of up to $215,000 from existing reserves will fund this action. Any additional or ongoing expenditures related this action will be included in the CalOptima FY 2022-23 Operating Budget.

Recommended Action #2: The recommended action is unbudgeted. An allocation of up to $200,000 from existing reserves will fund this action. Any additional or ongoing expenditures related this action will be included in the CalOptima FY 2022-23 Capital Budget.

Recommended Action #3: Funding of up to $50,000 is included as part of the 505 Building Improvements – Office Suite Renovation and Improvements budget under the CalOptima Fiscal Year 2021-22 Capital Budget.

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Rationale for Recommendation

Staff recommends approval of the recommended action to protect CalOptima's property and assets and to keep them fully functional and operational in accordance with State and Federal guidelines. Authorization of the expenditures will allow CalOptima to provide a professional work environment for our employees and partners.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachment

1. Entities Covered by this Recommended Board Action

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Western Audio Visual	5365 Avenida Encinas	Orange	CA	92867
Red-E Services	1409 Kuehner Drive	Simi Valley	CA	93063
RiverRock	505 City Parkway West, Suite 160	Orange	CA	92868
Pacific Polymers Inc,	PO BOX 190	Herald	CA	95638
Office Furniture Group	18650 MacArthur Blvd., #400	Irvine	CA	92612
Center Wallcovering & Painting Inc.	640 North Eckhoff Street	Orange	CA	92868

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Revisions to CalOptima's Fiscal Year 2021-22 Multipurpose Senior Services Program Operating Budget

Contact

Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Actions

Approve parameters for revisions to CalOptima's Fiscal Year (FY) 2021-22 Multipurpose Senior Services Program (MSSP) Operating Budget

Background/Discussion

MSSP is a home and community-based services program that operates pursuant to a waiver in the State's Medi-Cal program to provide case management of social and health care services as a cost-effective alternative to institutionalization of the frail elderly. The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). CDA contracts with local government entities and private non-profit organizations to administer the program statewide. As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past 20 years for up to a maximum of 455 members at any given point in time. Currently, CalOptima serves 455 members.

At the October 7, 2021, meeting, the Board adopted Resolution No. 21-1007-01 to execute Contract MS-21-22-41 to continue operations of the MSSP through June 30, 2022. The maximum amount of the contract was $2,437,371. On December 23, 2021, CalOptima received a contract amendment from CDA that increases the maximum amount to $2,739,640 (or a net increase of $302,569) for the period of January 1, 2022, through June 30, 2022. CDA has allocated 113 new member slots, increasing the maximum members served from 455 to 568. Upon further analysis of these changes, staff recommends consideration and approval of a revised FY 2021-22 MSSP Operating Budget.

Fiscal Year (FY) 2021-22 Budget Revision Parameters

At the June 3,2021 meeting, the Board approved the CalOptima FY 2021-22 Operating Budget, which included allocation of funds related to the MSSP within the Medi-Cal line of business. The budget included revenue, medical costs, and administrative expenses for the MSSP. Table 1 below provides a revised income and spending plan for the MSSP for FY 2021-22.

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Table 1: FY 2021-22 MSSP Budget

	FY 2021-22 Approved Budget	Slot Increase Projection	FY 2021-22 Budget - Reforecast
Average Monthly Enrollment	455	113	568
Revenue	$1,218,536	$302,569	$1,521,105
Medical Costs	$881,391	$209,124	$1,090,515
Administrative Expenses	$434,649	$73,025	$507,674
Operating Income/Loss	**($97,505)**	**$20,420**	**($77,085)**
MLR	72.3%		71.7%
ALR	35.7%		33.4%

Budget Assumptions
Enrollment: Enrollment is projected to increase to a total of 568 members by June 2022.

Revenue: The increase in revenue is anticipated to fund increased medical costs and administrative expenses for new MSSP members.

Medical Cost: Medical cost will include waiver services and 3 staff positions to provide member care.

Administrative Expenses: Administrative expenses will include 2 staff positions to support the MSSP.

CalOptima will continue to follow the Coordinated Care Initiative (CCI) payment model, in which DHCS provides CalOptima revenue based on current MSSP members in the established capitation rate setting process. The payment structure is expected to transition back to fee-for-service effective January 1, 2022, with MSSP returning to the 1915(c) Medicaid Waiver.

Fiscal Impact
The proposed revision to the CalOptima FY 2021-22 MSSP Operating Budget reflects an overall deficit of $77,085.

Rationale for Recommendation
Staff recommends approval of the recommended action to accommodate for the newly approved slots announced by the CDA and provide adequate services to our MSSP members.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments
1. Attachment A: Revised Fiscal Year 2021-22 MSSP Operating Budget

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Attachment A: Revised Fiscal Year 2021-22 MSSP Operating Budget

	MSSP FY 2022 Board Approved	Increase	MSSP Total
Member Months	2,730	678	**3,408**
Avg Members	455	113	**568**
Revenues			
Capitation revenue	$ 1,218,536	$ 302,569	**$ 1,521,105**
Total	$ 1,218,536	$ 302,569	**$ 1,521,105**
Medical Costs			
1 Provider capitation	$ -	$ -	**$ -**
2 Claims Payments	$ -	$ -	**$ -**
3 LTC/Skilled Nursing Facilities	$ 158,409	$ 39,341	**$ 197,750**
4 Prescription Drugs	$ -	$ -	**$ -**
5 Case Mgmt & Oth Medical	$ 722,982	$ 169,783	**$ 892,765**
Total	$ 881,391	$ 209,124	**$ 1,090,515**
MLR	*72.3%*		*71.7%*
Gross Margin	$ 337,145	$ 93,445	**$ 430,590**
Administrative Expenses			
Salaries, Wages, & Employee Benefits	$ 354,746	$ 73,025	**$ 427,771**
Professional Fees	$ 6,750	$ -	**$ 6,750**
Purchased services	$ -	$ -	**$ -**
Printing & Postage	$ -	$ -	**$ -**
Depreciation & Amortization	$ -	$ -	**$ -**
Other Operating Expenses	$ 43,846	$ -	**$ 43,846**
Indirect Cost Allocation, Occupancy Expense	$ 29,307	$ -	**$ 29,307**
Total	$ 434,649	$ 73,025	**$ 507,674**
ALR	*35.7%*		*33.4%*
Operating Income/(Loss)	$ (97,505)	$ 20,420	**$ (77,085)**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
7. Approve Modifications to Policy GA.5004: Travel Policy

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Approve modifications to CalOptima Policy GA.5004: Travel Policy

Background & Discussion
At the September 6, 2012, meeting, the CalOptima Board of Directors (Board) approved modifications to the previous Travel Policy that was effective September 10, 1996. CalOptima staff regularly reviews agency policies and procedures to ensure that they are up-to-date. Since the policy applies to Board members, as well as to employees, contractors, and others who conduct business on CalOptima's behalf, staff is seeking Board approval on changes and clarifications to the policy to reflect current regulations and updated processes.

Below is a list of recommended substantive updates to the policy, which are reflected in the attached redline version. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Policy Section	Change
II.A and II.B	Clarifies compliance with applicable laws and regulations for business-related expenses, including Internal Revenue Service requirements
II.C.1	Updates reimbursable travel expenses to include taxi and recognized ride-share companies and adds guidance on policy and procedures for travel expenses
II.C.2	Provides additional guidance on policy and procedures for vendors and consultants conducting CalOptima business where lodging is reimbursed
II.C.3	Updates the maximum amount of reimbursable travel meals, including tax and gratuities
II.C.5	Adds policy on reimbursable miscellaneous expenses not addressed elsewhere in the policy
II.D.1	Adds list of social functions and/or events that are not reimbursable
II.E	Updates policies and procedures for cash advances
III.A	Adds Executive Director to the Travel and Training Authorization Form approval hierarchy and updates approver for CEO and Board Member/Standing Committee Member; updates policies and procedures for travel and training requests

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Policy Section	Change
III.C	Adds Executive Director to the report approval hierarchy and updates approver for CEO and Board Member/Standing Committee Member; updates submission timeline to process expense reports
IX	Adds Glossary of terms and definitions

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation
The proposed changes to CalOptima Policy GA.5004: Travel Policy addresses pertinent changes, aligns policy with current operations, and provides greater clarity on reimbursable travel expenses and procedures.

Concurrence
Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments
1. Policy GA.5004: Travel Policy – redline and clean versions

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Policy:	GA.5004
Title:	**Travel Policy**
Department:	Finance
Section:	Not Applicable
Interim CEO Approval:	*/s/*
Effective Date:	08/01/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20220303 BOD Review Only

I. PURPOSE

~~To establish a~~This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, transportation, meals, ~~lodging,~~ and other actual and necessary business-related expenses incurred by CalOptima employees, ~~Board members~~Governing Body, Standing Committee members, and authorized contractors and consultants while ~~traveling on~~conducting authorized CalOptima Business.

II. POLICY

~~A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.~~

~~B.~~A. ~~CalOptima shall provide an expense~~CalOptima shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Travel Meals, Transportation, Registration Fees, and other Reimbursable Expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel ~~expenses~~, transportation, meals, lodging, and miscellaneous expenses incurred by ~~authorized~~Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

~~B. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and~~CalOptima shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Business. Reimbursements for CalOptima business-related expenses shall be made in accordance with the Internal Revenue Services (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such individual is regularly employed.

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C. Business-related expenses for travel while conducting CalOptima Business must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. ~~-~~This includes making reservations for air travel and other expenses as soon as possible to access better rates~~.~~, avoiding peak travel times, and leveraging efficiency by combining multiple meetings and events wherever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

~~1. Travel Expenses shall include the following items:~~

~~1.~~ Transportation: ~~including~~Including commercial carriers, rental vehicles~~, and~~ mileage for use of personal vehicle~~;~~
, taxi, recognized ride-share companies, shuttle, and

~~2. Lodging;~~

~~3. Meals;~~

~~4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;~~

~~5. Insurance for rental vehicles;~~

~~6. Parking fees and tolls fees (i.e., toll roads and necessary parking);~~

~~7. Miscellaneous expenses including:~~

~~b. i. Authorized local and long-distance telephone calls;~~

~~ii. Baggage fees;~~

~~iii. Internet or Wi Fi charges;~~

~~iv. Facsimiles;~~

~~v. Expenses in connection with the preparation of authorized company reports or correspondence;~~

~~8.~~1. ~~vi.~~ ~~Taxi or~~ public transit fares~~, required to conduct business; and~~.

~~vii. Other unforeseen or unusual expenses that are properly justified and substantiated.~~

~~D. Board Member/Standing Committee Member Travel~~

~~1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.~~

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a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

a. Attendance at any given conference and/or seminar shall be:

i. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

ii. Approved by Human Resources.

b.a. Payment of Fees

a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and

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seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

a. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

b. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

a. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

a. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

b.a. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging

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facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

c. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

d. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

i. It results in offsetting lower airfare; and

ii.i. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

e.a. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

i. It is not practical or feasible for the authorized Individual to return home due to an extended commutethe mode of .

a. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

b. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

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5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

a. The mode of transportation, the Authorized Individual shall be based onconsider the distance of the final destination from the Individual'sindividual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.Transportation.

b. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

c.b. The Individual shall make transportationThe Authorized Individual shall make Transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation.Transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

i. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

ii. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

iii.i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance bywithin the CEO.Travel and Training Authorization form. An Authorized Individual shall pay any increase in transportationTransportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

iv.ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

v.iii. Whenever available, all Authorized Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved, unless First or Business Class is shown to be cheaper than coach.

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~~vi.~~iv. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

~~vii.~~v. Any deviation from the lowest available rate for commercial carriers shall be at the ~~Individual's~~individual's expense.

~~d.~~c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform CalOptima's ~~Purchasing~~Vendor Management Department of any such cancellations.

~~e.~~d. Use of Privately-Owned Vehicles

i. An ~~authorized~~Authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The ~~Individual~~individual must be licensed~~,~~ and shall carry liability insurance as required by the State of California, at the ~~Individual's~~individual's sole expense.

ii. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate~~.~~ to be reviewed annually. Total mileage reimbursed should ~~consider~~exclude the ~~Individual's~~individual's daily commute~~.~~ (Offset Mileage).

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Policy GA. 8042: Supplemental Compensation, CalOptima will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary workplace. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

~~iii.~~iv. CalOptima shall not reimburse costs for fuel, automobile repairs, ~~or~~ other automobile expense items, or traffic/parking citations.

~~iv.~~v. If more than one ~~authorized~~Authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

~~v.~~vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

~~vi.~~vii. CalOptima shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the ~~Individual's~~person's insurance policy, whichever is the lesser amount, for each accident.

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~~f.~~e. Rental Automobiles

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima than other means of ~~transportation~~Transportation.

~~ii.~~ Advance reservations shall be made whenever possible. Reservations for ~~employees, Board~~ the Authorized Individual and ~~Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.~~

~~iii.~~ii. ~~The~~ the vehicle rental agreement ~~for the authorized Individual shall reference the Individual's~~shall be made in the person's name, acting for CalOptima. i.e., John Doe, for CalOptima.

~~iv.~~iii. Rental automobile approved classes are as follows:

a) ~~i.~~ Economy Class~~: An~~ or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) ~~or fewer individuals~~Authorized Individuals, including the driver, will be passengers in the rental automobile at ~~any one~~ any one time.

b) ~~ii.~~ Mid-size Class~~: An~~ or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more ~~than four (4) individuals~~Authorized Individuals will be riding in the rental automobile at any one (1) time, or in ~~the~~ the event an economy class vehicle is not available, and the nature of the travel requires ~~immediate departure.~~ or if the cost is lower than that of an economy class (Documented support required).

c) ~~iii.~~ Luxury Class~~:~~ or equivalent: Under no circumstances shall an ~~Individual~~individual select a luxury class vehicle.

f. Other Modes of Transportation

i. ~~-~~Taxi Fares~~:~~ or Shuttles: CalOptima shall reimburse taxi fares or shuttles when public ~~transportation~~Transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

ii. Ride Sharing Company: CalOptima does not encourage the use of Ride Sharing Companies, such as Uber or Lyft; however, if no other modes of transportation is available or economical, CalOptima will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima, understanding the dangers of using such services. Customary and reasonable transportation tips/gratuity may be reimbursed.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with a business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima in accordance with this Policy.

2. Lodging

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a. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-local Travel.

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged, and booking through online travel websites, as opposed to directly with the lodging facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

c. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) website: https://www.gsa.gov/travel/plan-book/per-diem-rates.

d. CalOptima maintains preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima, should utilize these preferred hotels. Authorized Individuals should contact a member of the CalOptima Vendor Management Department for information and a link to the reservations department of these preferred hotels.

e. CalOptima may reimburse additional lodging expenses for Non-local Travel if:

i. It results in offsetting lower airfare; and

ii. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

ii. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day.

g. Once approved, the Authorized Individual or his or her Designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Vendor Management Department.

h. The Authorized Individual shall be responsible for necessary cancellation of travel and lodging reservations in accordance with the respective rules and time limits. CalOptima shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform CalOptima's Vendor Management Department of any cancellations.

3. Travel Meals

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a. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

b. CalOptima may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to 20% of the Authorized Individual's meal) and excluding alcoholic beverages in an amount not to exceed eighty dollars ($80.00) per day.

c. Under certain conditions, CalOptima may reimburse employees and Board members for Travel Meals that exceed the eighty dollars ($80.00) per day limit. The employee or Board member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

i. Extraordinary circumstances may cause it to be impractical or unfeasible for the Authorized Individual to stay within the established meal rates, and the Authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

ii. Expense Reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her Designee.

d. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member Travel Meal reimbursement rate.

4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

a. Attendance at any given conference and/or seminar shall be:

i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated Approver as specified below for that particular conference or seminar;

ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

iii. Approved by the Department Head and Human Resources.

b. Payment of Fees

i. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization Form is prepared and will submit necessary registration information to the Vendor Management Department.

ii. In the event an individual must personally pay for conference or seminar Registration Fees, the individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

5. Miscellaneous expenses, including:

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a. Insurance for rental vehicles;

b. Parking fees and toll fees (i.e., charges for toll roads and necessary parking);

c. Authorized local and long-distance telephone calls;

d. Baggage fees;

e. Internet or Wi-Fi charges for business-related communication;

f. Facsimiles;

g. Expenses in connection with the preparation of authorized company reports or correspondence; and

h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position.

b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events.

c. Expenses for anyone other than the Authorized Individual attending or participating in the activity or function.

d. The personal portion of any travel.

e. Entertainment expenses, including movies, sporting events, or concerts.

f. Personal losses incurred while on CalOptima business.

D. CalOptima may reimburse the reasonable cost of Business Meals for required meetings, trainings, or other functions where CalOptima business is conducted. Expenditure of or reimbursement with CalOptima funds is only permitted for Business Meals if such expenditure is pre-authorized in writing by the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO) prior to the meeting, training or other business-related function. Under no circumstances or conditions will Business Meals, payments or reimbursements be permitted for:

1. Social functions or events, including, but not limited to, the following:

a. Holiday parties (with the exception of an organization-wide event);

b. Birthdays;

c. Baby showers;

d. Marriage celebrations;

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e. Retirements;

f. Department-only employee appreciation or celebration;

g. Other personal employee celebrations;

h. Expenditures for alcoholic beverages, including related tax and tip; and/or

i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department).

E. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for travel expenses.

2. CalOptima may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff will need to approve requests for cash advances for anticipated authorized travel.

4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including transportation, meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the CFO.

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred, whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate and remit any cash amounts due back to CalOptima within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the individual will be processed in the following pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

III. PROCEDURE

A. Travel and Training Authorization Form

1. ~~Shall be accessed~~All travel requests and ~~completed~~requests for anticipated reimbursement of related expenses must be submitted on-line by ~~all~~Authorized Individuals or their ~~designee~~Designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

~~Shall~~

2. Such requests shall be routed for approval ~~systemically~~ based on the Authorized Individual's level, cost center, and whether ~~they are~~ the Authorized Individual is a CalOptima employee according to the following:

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a. Individual Departments are responsible for including anticipated travel expenses in the Department budget.

b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Senior Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	**Approver**
Employee through Department Manager	Department Director
~~Shall~~Department Director	Executive Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

c. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Policy GA.5003: Budget and Operations Forecasting prior to travel expenses being incurred.

3. All requests will also be routed ~~systemically~~ to the Human Resources Department in order to track the Authorized Individual's training.

4. ~~Shall also be routed systemically to the~~ The Finance Department ~~for confirmation~~will review all requests to verify that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The ~~Purchasing~~ Vendor Management Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel ~~commitments.~~arrangements if not already completed by the Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event ~~registration fees~~Registration Fees shall be pre-paid and processed by CalOptima's ~~Purchasing~~Vendor Management Department, where possible. CalOptima's ~~Purchasing~~Vendor Management Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Authorized Individual for the event.

2. The requestor, or his or her ~~designee~~Designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. ~~-~~Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's ~~Purchasing~~Vendor Management Department~~.~~ and will be reimbursed using an Expense Report.

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3. All other arrangements shall be made with the Authorized Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's ~~Purchasing~~Vendor Management Department approval.

C. Expense Reimbursement using an Expense Report

1. Authorized Individuals or ~~designees~~Designees shall prepare and submit request claims for reimbursement of ~~Travel Expenses~~travel expenses on a CalOptima Expense Report. The report shall be completed by the ~~Individual~~individual or ~~designee~~Designee, including all details, receipts and documentation, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive ~~Management~~Staff
Executive ~~Officer~~Director	~~CEO~~Departmental Chief or ~~designee*~~Designee
~~CEO~~Departmental Chief Officers	~~Board Chairperson~~CEO or ~~designee*~~Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	~~Board Chairperson,~~ CEO or ~~designee*~~Designee

*Designee authorization is not valid when self-approval would result.

2. Receipts

a. ~~For any expenses in excess of twenty-five dollars ($25.00), the Individual~~For each expense, the individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. The receipt shall include line item details of all eligible charges being submitted for reimbursement. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure, identifying the line item(s) for qualifying charges, as appropriate.

b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11-inch sheet of paper. Hotel receipts and other larger receipts may be submitted as-is.

c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

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3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel~~.~~, but in no event beyond sixty (60) days after the expense is paid or incurred.

4. No reimbursement shall be made for Expense Reports submitted beyond ~~six (6) months~~sixty (60) days after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. ~~Code expenses to~~During the review, Accounting will contact Authorized Individual to request for missing supporting documentation'

b. Accounting will provide advance communication of any denied reimbursement claims; and

c. Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The ~~Purchasing~~Vendor Management Department shall:

1. Provide travel reports to the CEO, Executive ~~Management,~~Staff and Department Directors, upon request.~~ Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.~~.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by ~~Purchasing~~Vendor Management to arrange attendance at conferences, ~~training~~trainings, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENT(S)

~~Electronic Travel and Training Authorization Form~~

A. CalOptima Expense Report

~~B. Cash Advance Form~~

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

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B. CalOptima Policy GA.8042: Supplemental Compensation
~~B.~~C. Internal Revenue Service Publication 463
~~C.~~D. California Government Code Section 53232.2
E. California Labor Code Section 2802
F. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	TBD	GA.5004	Travel Policy	Administrative

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IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report ~~***expense report***~~ for reimbursement of travel, meal, lodging, or other allowable expenses, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima ~~e~~Employees, and individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses.
Approved Lodging Facility	Any overnight sleeping facilities ~~lodging facility~~ which offers a discounted government rate to authorized individuals traveling on behalf of CalOptima. ~~In the event that a government rate is not available, CalOptima staff will make every effort to negotiate the best possible rate.~~
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes ~~Food and meals~~ where business is discussed with peers or business associates over the course of a meal ~~and may include the meal costs of others in attendance~~.
CalOptima Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima.
CalOptima Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses a person ~~either company or out of pocket,~~ incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and ~~that~~ does not generally include an overnight stay.
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.
Non-~~L~~local Travel	Travel which is ~~of sufficient distance~~more than 50 miles away from the primary workplace or home and may ~~so as to~~ require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
Provider Advisory Committee (PAC)	A committee comprised of Providers, representing a cross-section of the broad Provider community that serves Members, established by

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Term	Definition
	CalOptima to advise its Board of Directors on issues impacting the CalOptima Provider community.
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Travel expenses which are reasonable, actual, and necessary to accomplish CalOptima's business purposes and are eligible for reimbursement. Reimbursable expenses include but are not limited to the cost of transportation, meals, lodging, registration fees, insurance for rental vehicles and other incidental expenses incurred while traveling on CalOptima business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, ~~limo~~shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima business that is considered Non-l~~L~~ocal Travel.~~siness while away from primary workplace.~~

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Policy:	GA.5004
Title:	**Travel Policy**
Department:	Finance
Section:	Not Applicable
Interim CEO Approval:	*/s/*
Effective Date:	08/01/2012
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

This policy establishes a uniform standard and process for reasonable and equitable reimbursement of approved travel, transportation, meals, lodging, and other actual and necessary business-related expenses incurred by CalOptima employees, Governing Body, Standing Committee members, and authorized contractors and consultants while conducting authorized CalOptima Business.

II. POLICY

A. CalOptima shall comply with all applicable laws and regulations to provide and reimburse Authorized Individuals for business-related expenses, which includes travel, Travel Meals, Transportation, Registration Fees, and other Reimbursable Expenses. The Finance Department shall implement an approval and reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel, transportation, meals, lodging, and miscellaneous expenses incurred by Authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal laws and regulations.

B. CalOptima shall reimburse Authorized Individuals for reasonable, actual, and necessary expenses incurred while conducting CalOptima Business. Reimbursements for CalOptima business-related expenses shall be made in accordance with the Internal Revenue Services (IRS) requirements, particularly the rules for an accountable plan, which requires: (1) expenses to have a business connection; (2) expenses be adequately accounted for within a reasonable period of time; and (3) any excess reimbursement or allowance be returned within a reasonable period of time. Reimbursement may be authorized when there is a clear connection or nexus between the attendance of the individual at such activity or function and the performance of official duties for which such individual is regularly employed.

C. Business-related expenses for travel while conducting CalOptima Business must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates, avoiding peak travel times, and leveraging efficiency by combining multiple meetings and events wherever possible. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible. Reimbursable travel expenses include actual and necessary expenses, such as:

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1. Transportation: Including commercial carriers, rental vehicles, mileage for use of personal vehicle, taxi, recognized ride-share companies, shuttle, and public transit fares.

   a. In selecting the mode of Transportation**,** the Authorized Individual shall consider the distance of the final destination from the individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of Transportation.

   b. The Authorized Individual shall make Transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of Transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

      i. Authorized Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance within the Travel and Training Authorization form. An Authorized Individual shall pay any increase in Transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time but shall be charged to the appropriate type of leave.

      ii. Additional expenses shall not be the responsibility of the Authorized Individual if, through no fault or control of the Authorized Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

      iii. Whenever available, all Authorized Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved, unless First or Business Class is shown to be cheaper than coach.

      iv. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

      v. Any deviation from the lowest available rate for commercial carriers shall be at the individual's expense.

   c. The Authorized Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform CalOptima's Vendor Management Department of any such cancellations.

   d. Use of Privately-Owned Vehicles

      i. An Authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The individual must be licensed and shall carry liability insurance as required by the State of California, at the individual's sole expense.

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ii. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate to be reviewed annually. Total mileage reimbursed should exclude the individual's daily commute (Offset Mileage).

iii. For Authorized Individuals who receive an automobile allowance pursuant to CalOptima Policy GA. 8042: Supplemental Compensation, CalOptima will only reimburse actual mileage at the IRS Standard Mileage Rate for travel that exceeds a round-trip of 100 miles based on the distance of the final destination from the individual's primary workplace. Use of privately-owned vehicles within a round-trip of 100 miles or less per meeting or event based on the distance of the final destination from the individual's primary workplace is covered as part of the automobile allowance.

iv. CalOptima shall not reimburse costs for fuel, automobile repairs, other automobile expense items, or traffic/parking citations.

v. If more than one Authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

vi. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

vii. CalOptima shall compensate property damages to an Authorized Individual's automobile incurred without fault or cause on the part of the Authorized Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the person's insurance policy, whichever is the lesser amount, for each accident.

e. Rental Automobiles

i. An Authorized Individual may rent an automobile when such rental is considered to be more advantageous to CalOptima than other means of Transportation.

ii. Advance reservations shall be made whenever possible. Reservations for the Authorized Individual and the vehicle rental agreement shall be made in the person's name, acting for CalOptima. i.e., John Doe, for CalOptima.

iii. Rental automobile approved classes are as follows:

a) Economy Class or equivalent: An Authorized Individual shall select an economy class vehicle whenever four (4) or fewer Authorized Individuals, including the driver, will be passengers in the rental automobile at any one time.

b) Mid-size Class or equivalent: An Authorized Individual may select a mid-size class vehicle in the event more than four (4) Authorized Individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure or if the cost is lower than that of an economy class (Documented support required).

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c) Luxury Class or equivalent: Under no circumstances shall an individual select a luxury class vehicle.

f. Other Modes of Transportation

i. Taxi Fares or Shuttles: CalOptima shall reimburse taxi fares or shuttles when public Transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

ii. Ride Sharing Company: CalOptima does not encourage the use of Ride Sharing Companies, such as Uber or Lyft; however, if no other modes of transportation is available or economical, CalOptima will reimburse Ride Sharing Company fares. Authorized Individuals shall use Ride Sharing Companies at their own risk and discretion, with no liability to CalOptima, understanding the dangers of using such services. Customary and reasonable transportation tips/gratuity may be reimbursed.

g. Costs associated with any personal travel made in conjunction with a business travel itinerary will be at the Authorized Individual's expense. Authorized Individuals are expected to be honest in reporting any personal travel plans made in conjunction with a business travel, and the Authorized Individual shall document the incremental travel costs assessed to CalOptima in accordance with this Policy.

2. Lodging

a. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-local Travel.

b. Reasonable lodging expenses will be allowed. Price is a factor when selecting lodging, and prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged, and booking through online travel websites, as opposed to directly with the lodging facility, may provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

c. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) website: https://www.gsa.gov/travel/plan-book/per-diem-rates.

d. CalOptima maintains preferred rates with select hotels in the local area. Vendors and consultants conducting CalOptima Business who are required to stay overnight and are authorized to receive reimbursement for lodging expenses pursuant to a contract with CalOptima, should utilize these preferred hotels. Authorized Individuals should contact a member of the CalOptima Vendor Management Department for information and a link to the reservations department of these preferred hotels.

e. CalOptima may reimburse additional lodging expenses for Non-local Travel if:

i. It results in offsetting lower airfare; and

ii. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

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f. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

i. It is not practical or feasible for the Authorized Individual to return home due to extremely poor weather conditions; or

ii. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day.

g. Once approved, the Authorized Individual or his or her Designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Vendor Management Department.

h. The Authorized Individual shall be responsible for necessary cancellation of travel and lodging reservations in accordance with the respective rules and time limits. CalOptima shall not reimburse Authorized Individuals for fees associated with the failure to cancel reservations within the established rules and time limits unless the failure was due to circumstances beyond the control of the Authorized Individual. The Authorized Individual must also inform CalOptima's Vendor Management Department of any cancellations.

3. Travel Meals

a. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

b. CalOptima may reimburse Authorized Individuals the actual cost of Travel Meals, including taxes and gratuity (up to 20% of the Authorized Individual's meal) and excluding alcoholic beverages in an amount not to exceed eighty dollars ($80.00) per day.

c. Under certain conditions, CalOptima may reimburse employees and Board members for Travel Meals that exceed the eighty dollars ($80.00) per day limit. The employee or Board member shall submit a valid receipt for such Travel Meals along with a brief explanation of the expenditure which must meet the following conditions:

i. Extraordinary circumstances may cause it to be impractical or unfeasible for the Authorized Individual to stay within the established meal rates, and the Authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

ii. Expense Reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her Designee.

d. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member Travel Meal reimbursement rate.

4. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

a. Attendance at any given conference and/or seminar shall be:

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i. Limited to the minimum number of individuals necessary to carry out the business purpose as deemed appropriate by the designated Approver as specified below for that particular conference or seminar;

ii. For only those whose job tasks or responsibilities are directly related to the purpose of the travel; and

iii. Approved by the Department Head and Human Resources.

b. Payment of Fees

i. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization Form is prepared and will submit necessary registration information to the Vendor Management Department.

ii. In the event an individual must personally pay for conference or seminar Registration Fees, the individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

5. Miscellaneous expenses, including:

a. Insurance for rental vehicles;

b. Parking fees and toll fees (i.e., charges for toll roads and necessary parking);

c. Authorized local and long-distance telephone calls;

d. Baggage fees;

e. Internet or Wi-Fi charges for business-related communication;

f. Facsimiles;

g. Expenses in connection with the preparation of authorized company reports or correspondence; and

h. Other unforeseen or unusual business-related expenses that are properly justified and substantiated.

6. The type of expenses or occurrences that do not qualify for travel reimbursement of expenses include, but are not limited to:

a. Attendance at social, civic, or charitable meetings or functions, which the person would attend regardless of his or her position.

b. Any expenditure or contributions related to political campaigning or charitable fundraisers or events.

c. Expenses for anyone other than the Authorized Individual attending or participating in the activity or function.

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d. The personal portion of any travel.

e. Entertainment expenses, including movies, sporting events, or concerts.

f. Personal losses incurred while on CalOptima business.

D. CalOptima may reimburse the reasonable cost of Business Meals for required meetings, trainings, or other functions where CalOptima business is conducted. Expenditure of or reimbursement with CalOptima funds is only permitted for Business Meals if such expenditure is pre-authorized in writing by the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO) prior to the meeting, training or other business-related function. Under no circumstances or conditions will Business Meals, payments or reimbursements be permitted for:

1. Social functions or events, including, but not limited to, the following:

a. Holiday parties (with the exception of an organization-wide event);

b. Birthdays;

c. Baby showers;

d. Marriage celebrations;

e. Retirements;

f. Department-only employee appreciation or celebration;

g. Other personal employee celebrations;

h. Expenditures for alcoholic beverages, including related tax and tip; and/or

i. Voluntary events or functions, including, but not limited to, employee lunch time and/or after work group outings, team building events, and/or other off-site social functions (with the exception of training and self-development programs established and/or approved by the Human Resources Department).

E. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for travel expenses.

2. CalOptima may authorize cash advances on a limited basis if the traveling Authorized Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized travel expenses.

3. A member of the Executive Staff will need to approve requests for cash advances for anticipated authorized travel.
4. When authorized, cash advances shall be based on an estimate of reasonable travel expenses, including transportation, meals, lodging and miscellaneous expenses, and shall have a limit of $1,000 unless approved in advance by the CFO.

5. Cash advances shall not be provided earlier than thirty (30) days prior to the scheduled travel date(s). Authorized Individuals receiving cash advances shall complete an Expense Report within sixty (60) days of when the Authorized Individual's expenses were paid or incurred,

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whichever occurs first. The Authorized Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate and remit any cash amounts due back to CalOptima within one hundred and twenty (120) days of when the expenses were paid or incurred in the event the cash advance was greater than actual authorized expenses. In the event the actual authorized expenses exceed the amount of the cash advance, cash amounts due the individual will be processed in the following pay period. Failure to return unexpended cash advances or to account for all expenses incurred while traveling may result in corrective action, up to and including termination.

III. PROCEDURE

A. Travel and Training Authorization Form

1. All travel requests and requests for anticipated reimbursement of related expenses must be submitted on-line by Authorized Individuals or their Designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Such requests shall be routed for approval based on the Authorized Individual's level, cost center, and whether the Authorized Individual is a CalOptima employee according to the following:

   a. Individual Departments are responsible for including anticipated travel expenses in the Department budget.

   b. Budgeted Expenses: All budgeted travel and miscellaneous expenses for Authorized Individuals must be approved by the appropriate level of CalOptima Senior Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

   c. Non-Budgeted Expenses: Non-budgeted travel and miscellaneous expenses for Authorized Individuals may be approved if the expenditures are appropriated and authorized in accordance with CalOptima Policy GA.5003: Budget and Operations Forecasting prior to travel expenses being incurred.

3. All requests will also be routed to the Human Resources Department in order to track the Authorized Individual's training.

4. The Finance Department will review all requests to verify that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

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6. The Vendor Management Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel arrangements if not already completed by the Vendor Management Department.

B. Travel and Training Arrangements

1. Authorizations that include event Registration Fees shall be pre-paid and processed by CalOptima's Vendor Management Department, where possible. CalOptima's Vendor Management Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Authorized Individual for the event.

2. The requestor, or his or her Designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Vendor Management Department and will be reimbursed using an Expense Report.

3. All other arrangements shall be made with the Authorized Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Vendor Management Department approval.

C. Expense Reimbursement using an Expense Report

1. Authorized Individuals or Designees shall prepare and submit request claims for reimbursement of travel expenses on a CalOptima Expense Report. The report shall be completed by the individual or Designee, including all details, receipts and documentation, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	**Approver**
Employee through Department Manager	Department Director
Department Director	Executive Staff
Executive Director	Departmental Chief or Designee
Departmental Chief Officers	CEO or Designee
Chief Executive Officer	CFO or Designee
Board Member/Standing Committee Member	CEO or Designee

*Designee authorization is not valid when self-approval would result.

2. Receipts

a. For each expense, the individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. The receipt shall include line item details of all eligible charges being submitted for reimbursement. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure, identifying the line item(s) for qualifying charges, as appropriate.

b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11-inch sheet of paper. Hotel receipts and other larger receipts may be submitted as-is.

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c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel, but in no event beyond sixty (60) days after the expense is paid or incurred.

4. No reimbursement shall be made for Expense Reports submitted beyond sixty (60) days after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

a. During the review, Accounting will contact Authorized Individual to request for missing supporting documentation'

b. Accounting will provide advance communication of any denied reimbursement claims; and

c. Authorized Individual may dispute denied reimbursement claims by providing a narrative and/or additional supporting documentation to be reviewed by the Controller.

2. Review expense codes for appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Vendor Management Department shall:

1. Provide travel reports to the CEO, Executive Staff and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Vendor Management to arrange attendance at conferences, trainings, and other events, and to make authorized purchases.

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5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENT(S)

A. CalOptima Expense Report

V. REFERENCE(S)

A. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994
B. CalOptima Policy GA.8042: Supplemental Compensation
C. Internal Revenue Service Publication 463
D. California Government Code Section 53232.2
E. California Labor Code Section 2802
F. Title 26, Code of Federal Regulations §§ 1.62-2

VI. REGULATORY AGENCY APPROVAL(S)

Not Applicable

VII. BOARD ACTION(S)

Date	Meeting
09/06/2012	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	08/01/2012	GA.5004	Travel Policy	Administrative
Revised	09/06/2012	GA.5004	Travel Policy	Administrative
Revised	03/01/2013	GA.5004	Travel Policy	Administrative
Revised	TBD	GA.5004	Travel Policy	Administrative

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IX. GLOSSARY

Term	Definition
Authorized Individual	Persons authorized to submit an Expense Report for reimbursement of travel, meal, lodging, or other allowable expenses, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima Employees, and individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses.
Approved Lodging Facility	Any overnight sleeping facilities which offers a discounted government rate to authorized individuals traveling on behalf of CalOptima.
Business Meals	Breakfast, lunch, dinner, snacks, refreshments, and related tips and taxes where business is discussed with peers or business associates over the course of a meal.
CalOptima Business	Activities or functions which a department head determines are directly related to or in support of the ordinary, necessary and/or required mission and business functions of CalOptima.
CalOptima Employees	Includes, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns, CalOptima Board members, and applicable contractors and consultants.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Executive Staff	Staff holding Executive level positions as designated by the Board of Directors.
Expense Report	Detailed and itemized report that tracks expenses a person incurred during the course of performing necessary job functions.
Governing Body	The Board of Directors of CalOptima.
Investment Advisory Committee (IAC)	A standing committee of the CalOptima Board of Directors who provide advice and recommendations regarding the organization's investments.
Local Travel	Travel to a destination that is 50 miles or less away from the primary workplace or home and does not generally include an overnight stay.
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.
Non-local Travel	Travel which is more than 50 miles away from the primary workplace or home and may require an overnight stay.
Non-Reimbursable Expenses	Expenses that are not a necessary part of or approved as part of the required travel. Commuting between a traveler's home and regularly assigned work location is not considered official business.
Parking, Fees and Tolls	Charges for ferries, bridges, tunnels, toll roads, and necessary parking.
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.

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Term	Definition
Registration Fees	Actual fees paid for registration to attend authorized conferences, seminars, conventions, trainings or meetings of professional societies or community organizations.
Reimbursable Expenses	Travel expenses which are reasonable, actual, and necessary to accomplish CalOptima's business purposes and are eligible for reimbursement. Reimbursable expenses include but are not limited to the cost of transportation, meals, lodging, registration fees, insurance for rental vehicles and other incidental expenses incurred while traveling on CalOptima business.
Standing Committee Members	Non-Board and non-employee members of the CalOptima Investment Advisory Committee (IAC), Provider Advisory Committee (PAC), Member Advisory Committee (MAC), OneCare Connect MAC, and Whole Child Model Family Advisory Committee.
Transportation	Bus, rail or airfare, car rental, taxi, ride sharing, shuttle, parking fees, tolls, and mileage for use of personal vehicle.
Travel Meals	Travel Meals are those food items consumed when traveling on CalOptima business that is considered Non-local Travel.

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2022 Expense Report

Line of Business (LOB): _____ Employee ID# _____

Name _____ Dept. Cost Center _____

	DATE RANGE								TOTALS
1.	Mileage Reimbursement 1								$ -
2.	Parking and Tolls								$ -
3.	Auto Rental								$ -
4.	Taxi/Shuttle/Other								$ -
5.	Airfare								$ -
	Transportation Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ -
6.	Lodging								$ -
7.	Other								$ -
8.	Breakfast								$ -
9.	Lunch								$ -
10.	Dinner								$ -
	Sub-Total Meals (Lessor of Actual or Daily Max)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ -
	Lodging & Meals Total (Travel)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ -
11.	Supplies/Equipment								$ -
12.	Phone, Fax, Internet								$ -
13.	Catering								$ -
14.	Business Meals								$ -
15.	Other								$ -
16.	*Other*								$ -
	Miscellaneous Total	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$ -

DETAILED EXPENSE RECORD

Line # or Range	Date	Person and Business Relationship	Place Name & Location	Business Purpose for above expenses (If not on TTA)	Amount

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SUMMARY REIMBURSEMENT

TOTAL EXPENSES	$ -
LESS CASH ADVANCE	$ -
AMOUNT DUE EMPLOYEE	$ -
AMOUNT DUE CALOPTIMA	$ -

EMPLOYEE SIGNATURE DATE

MANAGEMENT APPROVAL * DATE

PRINTED APPROVER NAME DATE

ACCOUNTING REVIEW

Instructions:

1. Transfer daily mileage total calculated dollar amounts from the separate mileage form.
2. Submit and retain line item receipts (Line item example: Receipts shows separate lines for dinner entrees, beverages, salad, tax, tip, etc.; Not just a receipt with the total for all)) taped to a separate 8.5" X 11" sheet. Receipts exceptions require explanation & additional approvals.
3. Gift card purchases MUST be approved by Accounting in advance
4. Attach a copy of the Travel & Training Authorization Form for all travel and training reimbursements.
5. IRS regulations require that you provide business purpose for all expenses. https://www.irs.gov/publications/p463
6. Maximum reimbursement for travel and training meals is $45.00 per day per employee. Note the names of all employees included.
7. Use this report for expenses incurred in calendar year 2022 (rate is 58.5 cents per mile).
8. Per travel policy GA.5004, no reimbursement shall be made for expense reports submitted beyond six (6) months after completion of travel.
9. The Expense Report form requires management approval per check request policy GA.5006, which designates approval levels for a document authorizing the expenditure of company funds.

* Approval Limits per GA.5006 Policy	Authority Limit
Manager	$1,000
Director	10,000
Executive Director or Officer	100,000
Chief Executive Officer	Over 100,000
Chief Financial Officer and Chief Executive Officer	Over 250,000

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Mileage Log and Reimbursement Form

Employee ID	0	**IRS Rate Per Mile**	**0.585**
Employee Home Zip Code		**For Period**	**From 1/00/00 to 1/00/00**
Dept. Cost Center	0	**Total Reimbursable Mileage**	100
Employee (Initials) 4		**Total Reimbursement**	58.5
Dept. Mgmt. Approval (Initials) 4			

Date	Starting Location	Zip Code	Destination	Zip Code	Description/Notes	Mileage	3 Offset Mileage	Amount
						100		$58.50
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
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						0	0	$0.00
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						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
						0	0	$0.00
					Totals	**100**	**0**	**$58.50**

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Instructions:

Transfer Daily Totals to Line 1 of the Exepense Report

1 Mileage reimbursement requests should be submitted MONTHLY and WITHIN 30 DAYS of the end of the month in which the expense was incurred.
2 Enter Actual Mileage and zip codes.
3 Offset Mileage
   a. Non-Teleworker- Per GA.5004 (5.b.) and IRS regulations, if the starting location is from the employee's home, the daily mileage total must be offset with the mileage normally required to drive to and from work (Daily Round Trip
   b. Teleworker- Per GA.8044 Telework Program policy (V.3.), Reimbursement is based on actual mileage, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and then back again, on a
4 Both the employee and their department's management must initial, indicating accuracy, validity and reasonableness for the mileage.
5 Transfer totals by day to the expense report form.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
8. Approve Modifications to Policy GA.3301: Capitalization Policy

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Approve modifications to CalOptima Policy GA.3301: Capitalization Policy

Background & Discussion
Policy GA.3301 which describes CalOptima's processes for determining and classifying capitalized assets was last updated on November 11, 2011. CalOptima staff regularly reviews agency policies and procedures to ensure that they are current and in accordance with Generally Accepted Accounting Standards (GAAP) and the Governmental Accounting Standards Board (GASB). As such, staff is seeking Board approval on changes and clarifications to the policy to reflect current regulations and updated processes.

Below is a list of recommended substantive updates to the policy, which are reflected in the attached redline version. The list does not include non-substantive changes that may also be reflected in the redline (i.e., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Policy Section	Change
II.K	Updates reference to new accounting standard applicable to classification of leases, GASB 87 – Lease Accounting
II.L.	Clarifies policy for capitalizing assets with component costs less than the Capitalization Threshold
V.B	Adds reference for GASB 87 – Lease Accounting
IX.	Adds Glossary and updates Capitalization Threshold from $2,000 to $5,000 to improve administrative efficiency and enhance overall control and stewardship of higher valued items

Fiscal Impact
The recommended action is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

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Rationale for Recommendation

The proposed revisions to CalOptima Policy GA.3301: Capitalization Policy addresses substantive changes, aligns policy with current operations, and ensures CalOptima is compliant with accounting standards.

Concurrence

Troy R. Szabo, Outside General Counsel, Kennaday Leavitt
Finance and Audit Committee

Attachments

1. Policy GA.3301: Capitalization Policy – redline and clean versions

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Policy:	GA.3301
Title:	**Capitalization Policy**
Department:	CalOptima Administrative
Section:	Finance, Accounting
Interim CEO Approval:	
Effective Date:	11/01/2011
Revised Date:	TBD
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20220303 BOD Review Only

I. PURPOSE

To provide clear and uniform guidance for determining the proper classification of an Asset and establish policies and procedures to classify and Capitalize Assets owned or leased by CalOptima.

II. POLICY

A. CalOptima shall classify and Capitalize Assets consistently.

B. CalOptima shall value new purchases, additions, and replacements at Cost, where Cost includes freight, installation, taxes, and other charges incurred to place the Asset in service.

C. CalOptima shall Capitalize major Building structural components, subsystems, and equipment separately based on their Asset class.

D. CalOptima shall expense internal and external Costs, incurred ~~to~~for Internally Developed Software during the Preliminary Project Stage of Software Development, as the Costs are incurred~~.~~.

E. CalOptima shall Capitalize internal and external Costs, incurred ~~to~~for Internally Developed Software during the Application Development Stage of Software Development.

F. CalOptima shall begin Capitalization when the Preliminary Project Stage of ~~Internally Developed~~ Software Development is complete.

G. CalOptima shall cease Capitalization of Internally Developed Software no later than the point at which a computer software project is substantially complete and ready for its intended use, and after all substantial testing is complete.

H. CalOptima shall expense internal and external Costs~~,~~ incurred during the ~~post-implementation/operation stage.~~ Post-Implementation Project Stage of Software Development. Activities in this stage include application training and software maintenance.

I. CalOptima shall Capitalize Costs to develop or obtain software that allows for access to or conversion of old data by new systems. ~~-~~However, data conversion Costs shall be expensed as incurred.

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J. CalOptima shall amortize or depreciate on a Straight-~~Line~~line Method.

K. CalOptima shall classify all leases in which CalOptima is a lessee as either a Capital or operating lease in accordance with ~~Accounting Standards Codification 840 – Leases of the Financial Accounting Standards Board (FASB) (previously FAS No. 13). Government~~Governmental Accounting Standards Board (GASB) ~~requires governmental entities to follow FASB guidance~~87 as defined in the June 2017 No. 366 Governmental Accounting Standards Series with a retroactive adoption date of June 15, 2021.

~~K.~~L. CalOptima shall Capitalize Assets with component Costs that are less than the Capitalization ~~t~~Threshold for ~~accounting and financial reporting of lease agreements.~~an individual Asset, whereby the asset in aggregate is equal to, or greater than the Capitalization ~~t~~Threshold as defined in the Glossary.

III. PROCEDURE

A. CalOptima shall Capitalize Assets used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.

B. The Accounting Department shall enter Capitalized and Controllable ~~Asset~~ Assets into the Fixed Asset module software system in accordance with CalOptima Policy GA.3302: Asset Management Policy.

C. The Accounting Department shall calculate Depreciation using the Straight-line Method effective the first day (1st) of the subsequent month the Asset was placed in service.

D. The Accounting Department shall reclassify assembled Fixed Assets from Construction In Progress (CIP) to a depreciable Fixed Asset when construction is complete and meets the Capitalization Threshold. The Fixed Asset Cost is the sum of components and service.

E. Categories and useful lives of Capitalized Assets shall be as follows:

Categories	**Useful Lives**
Furniture, fixtures, ~~and~~ equipment	5 years
Vehicles	5 years
Hardware and Software:	
Computers/Printers	3 years
Software – Internal development Costs	Based on development stage
Software – Commercial	3 years
Land, Buildings, and Improvements~~:~~:	
Land	~~not~~Not depreciated
Buildings	40 years
Improvements~~:~~:	
Building Components:	Based on components:
Building shell	30 years
Electrical and lighting systems	20 years
Elevator systems	20 years
Fire protection systems	20 years

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Categories	Useful Lives
Fixed equipment	20 years
Floor coverings	15 years
Heating, ventilation, cooling	15 years
Interior finish	15 years
Misc. construction features	15 years
Plumbing systems	20 years
Roof coverings	10 years
Land Improvements:	Based on improvement:
Fencing, brick ~~or~~, stone	25 years
Fencing, chain link ~~or~~, guardrails	15 years
Landscaping	10 years
Parking lot, open wall	20 years
Paving, asphalt	8 years
Water ~~and~~, sewer lines	20 years
Leasehold Improvements	The lesser of 15 years or the remaining term of lease~~.~~
Tenant Improvements	The lesser of 7 years or the remaining term of lease

1. The Accounting Department may adjust Asset lives as necessary depending on the present condition and use of the Asset and based on how long the Asset is expected to meet current service demands.

F. The Accounting Department shall determine expenditures to Capitalize ~~as~~ Buildings as follows:

1. Purchased Buildings

   a. Original purchase price;

   b. Expenses for remodeling, reconditioning, or altering a purchased Building to make it ready to use for the purpose for which it was acquired;

   c. Environmental compliance ~~to include~~including, but not limited to~~:~~, asbestos abatement;

   d. Professional fees ~~to include~~including, but not limited to~~:~~, architect, engineer, management fees for design and supervision, and legal services;

   e. Payment of unpaid or accrued taxes on the Building to date of purchase;

   f. Cancellation or buyout of existing leases; and

   g. Other costs required to place or render the ~~asset~~Asset into operation.

2. Constructed Buildings

   a. Completed project ~~costs~~Costs;

   b. Interest accrued during construction;

   c. Cost of excavation ~~or~~, grading or filling of land for a specific Building;

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d. Expenses incurred for the preparation of plans ~~to include~~including, but ~~is~~ not limited~~:~~., specifications and blueprints;

e. Cost of Building permits;

f. Professional fees ~~to include~~including, but not limited to~~:~~., architect, engineer, management fees for design and supervision, and legal services;

g. Costs of temporary Buildings used during construction;

h. Unanticipated Costs ~~to include~~including, but not limited to~~:~~., rock blasting, piling and relocation of the channel of an underground stream;

i. Permanently attached fixtures or machinery that cannot be removed without impairing the use of the Building; and

j. Additions to Buildings ~~to include~~including, but not limited to~~:~~., expansions, extensions, and enlargements.

G. CalOptima shall expense internal and external Costs, incurred ~~to~~for Internally Developed Software during the Preliminary Project Stage of Software Development, as the Costs are incurred. ~~-~~All expenditures related to the Preliminary Project Stage are related to the conceptual formulation and evaluation of alternatives, the determination of the existence of needed technology, and the final selection of alternatives for the development of the software.

H. CalOptima shall Capitalize internal and external Costs, incurred ~~to~~for Internally Developed Software during the Application Development Stage of Software Development. Expenditures ~~related to~~during the Application Development Stage of ~~a Project include~~Software Development relate to the design of the chosen path, ~~including~~ software configuration and interfaces, coding, installation to hardware, ~~and~~ testing, ~~including~~and the parallel processing phase~~.~~.. Training Costs, if incurred during this stage, are not considered Internally Developed Software Costs and shall be expensed.

IV. ATTACHMENT(S)

A. Summary: Capitalization Requirements by Project Development Stage

V. REFERENCE(S)

A. CalOptima Policy GA.3302: Asset Management Policy
~~A. CalOptima Policy AA.1100: Glossary of Terms~~
B. Governmental Accounting Standards Board (GASB) 87; June 2017 No. 366 Governmental Accounting Standards Series

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

None to Date

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	11/01/2011	GA.3301	Capitalization Policy	Administrative
Revised	TBD	GA.3301	Capitalization Policy	Administrative – Internal only

IX. GLOSSARY

Term	Definition
Application Development Stage of Software Development	The stage of software development related to the enhancement or upgrade of in-house software, including the design of the chosen path, software configuration and interfaces, labor, installation to hardware, testing, and the parallel processing phase.
Asset	A tangible or intangible item of value.
Building	A structure that is permanently attached to the land, has a roof, is partially or completely enclosed by walls and is not intended to be transportable or moveable.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Capitalization Threshold	The threshold for capitalized items is five thousand ($5,000) dollars.
Capitalize	To record an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capitalization	The recording of an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capital Asset	Capital Asset: Any asset used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.
Controllable Assets	Certain purchases that do not meet the criteria established for designation as a Capital asset, however, by their nature should be monitored for proper use and disposal. These controllable assets either render a critical function or put the organization at risk by their absence. Such items include but are not limited to laptops, computers, printers, minor furnishings, and general office equipment.
Cost	Cost includes freight, installation, taxes and other charges incurred to place the asset in use. Service and maintenance contracts are charged to prepaid expenses and amortized over the period of the contract.
Fixed Assets	Fixed assets or Capital assets are tangible assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed assets include buildings, machinery and equipment, computer equipment, vehicles, improvements, and land.
Internally Developed Software	Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima or commercially available software purchased or licensed by CalOptima.
Preliminary Project Stage of Software Development	The stage of software development related to the internal development of software that is new to the organization. which includes design, configuration, interfaces, labor, installation, testing, and evaluations of alternatives.
Post-Implementation Project Stage of Software Development	All expenditures related to the post-implementation of internally developed software. Expenditures include application maintenance, labor, and training.

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Term	Definition
Straight-line Method	A method to record the allocation of an asset's cost evenly over its useful life.

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For 20220303 BOD Review Only

Policy:	GA.3301
Title:	**Capitalization Policy**
Department:	CalOptima Administrative
Section:	Finance, Accounting
Interim CEO Approval:	
Effective Date:	11/01/2011
Revised Date:	TBD
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B. CalOptima shall value new purchases, additions, and replacements at Cost, where Cost includes freight, installation, taxes, and other charges incurred to place the Asset in service.

C. CalOptima shall Capitalize major Building structural components, subsystems, and equipment separately based on their Asset class.

D. CalOptima shall expense internal and external Costs, incurred for Internally Developed Software during the Preliminary Project Stage of Software Development, as the Costs are incurred.

E. CalOptima shall Capitalize internal and external Costs, incurred for Internally Developed Software during the Application Development Stage of Software Development.

F. CalOptima shall begin Capitalization when the Preliminary Project Stage of Software Development is complete.

G. CalOptima shall cease Capitalization of Internally Developed Software no later than the point at which a computer software project is substantially complete and ready for its intended use, and after all substantial testing is complete.

H. CalOptima shall expense internal and external Costs incurred during the Post-Implementation Project Stage of Software Development. Activities in this stage include application training and software maintenance.

I. CalOptima shall Capitalize Costs to develop or obtain software that allows for access to or conversion of old data by new systems. However, data conversion Costs shall be expensed as incurred.

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J. CalOptima shall amortize or depreciate on a Straight-line Method.

K. CalOptima shall classify all leases in which CalOptima is a lessee as either a Capital or operating lease in accordance with Governmental Accounting Standards Board (GASB) 87 as defined in the June 2017 No. 366 Governmental Accounting Standards Series with a retroactive adoption date of June 15, 2021.

L. CalOptima shall Capitalize Assets with component Costs that are less than the Capitalization Threshold for an individual Asset, whereby the asset in aggregate is equal to, or greater than the Capitalization Threshold as defined in the Glossary.

III. PROCEDURE

A. CalOptima shall Capitalize Assets used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.

B. The Accounting Department shall enter Capitalized and Controllable Assets into the Fixed Asset module software system in accordance with CalOptima Policy GA.3302: Asset Management Policy.

C. The Accounting Department shall calculate Depreciation using the Straight-line Method effective the first day (1st) of the subsequent month the Asset was placed in service.

D. The Accounting Department shall reclassify assembled Fixed Assets from Construction In Progress (CIP) to a depreciable Fixed Asset when construction is complete and meets the Capitalization Threshold. The Fixed Asset Cost is the sum of components and service.

E. Categories and useful lives of Capitalized Assets shall be as follows:

Categories	**Useful Lives**
Furniture, fixtures, equipment	5 years
Vehicles	5 years
Hardware and Software:	
Computers/Printers	3 years
Software – Internal development Costs	Based on development stage
Software – Commercial	3 years
Land, Buildings, and Improvements:	
Land	Not depreciated
Buildings	40 years
Improvements:	
Building Components:	Based on components:
Building shell	30 years
Electrical and lighting systems	20 years
Elevator systems	20 years
Fire protection systems	20 years
Fixed equipment	20 years
Floor coverings	15 years
Heating, ventilation, cooling	15 years
Interior finish	15 years

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Categories	Useful Lives
Misc. construction features	15 years
Plumbing systems	20 years
Roof coverings	10 years
Land Improvements:	Based on improvement:
Fencing, brick, stone	25 years
Fencing, chain link, guardrails	15 years
Landscaping	10 years
Parking lot, open wall	20 years
Paving, asphalt	8 years
Water, sewer lines	20 years
Leasehold Improvements	The lesser of 15 years or the remaining term of lease
Tenant Improvements	The lesser of 7 years or the remaining term of lease

1. The Accounting Department may adjust Asset lives as necessary depending on the present condition and use of the Asset and based on how long the Asset is expected to meet current service demands.

F. The Accounting Department shall determine expenditures to Capitalize Buildings as follows:

1. Purchased Buildings

   a. Original purchase price;

   b. Expenses for remodeling, reconditioning, or altering a purchased Building to make it ready to use for the purpose for which it was acquired;

   c. Environmental compliance including, but not limited to, asbestos abatement;

   d. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

   e. Payment of unpaid or accrued taxes on the Building to date of purchase;

   f. Cancellation or buyout of existing leases; and

   g. Other costs required to place or render the Asset into operation.

2. Constructed Buildings

   a. Completed project Costs;

   b. Interest accrued during construction;

   c. Cost of excavation, grading or filling of land for a specific Building;

   d. Expenses incurred for the preparation of plans including, but not limited, specifications and blueprints;

   e. Cost of Building permits;

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f. Professional fees including, but not limited to, architect, engineer, management fees for design and supervision, and legal services;

g. Costs of temporary Buildings used during construction;

h. Unanticipated Costs including, but not limited to, rock blasting, piling and relocation of the channel of an underground stream;

i. Permanently attached fixtures or machinery that cannot be removed without impairing the use of the Building; and

j. Additions to Buildings including, but not limited to, expansions, extensions, and enlargements.

G. CalOptima shall expense internal and external Costs, incurred for Internally Developed Software during the Preliminary Project Stage of Software Development, as the Costs are incurred. All expenditures related to the Preliminary Project Stage are related to the conceptual formulation and evaluation of alternatives, the determination of the existence of needed technology, and the final selection of alternatives for the development of the software.

H. CalOptima shall Capitalize internal and external Costs, incurred for Internally Developed Software during the Application Development Stage of Software Development. Expenditures during the Application Development Stage of Software Development relate to the design of the chosen path, software configuration and interfaces, coding, installation to hardware, testing, and the parallel processing phase. Training Costs, if incurred during this stage, are not considered Internally Developed Software Costs and shall be expensed.

IV. ATTACHMENT(S)

A. Summary: Capitalization Requirements by Project Development Stage

V. REFERENCE(S)

A. CalOptima Policy GA.3302: Asset Management Policy
B. Governmental Accounting Standards Board (GASB) 87; June 2017 No. 366 Governmental Accounting Standards Series

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	11/01/2011	GA.3301	Capitalization Policy	Administrative
Revised	TBD	GA.3301	Capitalization Policy	Administrative – Internal only

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IX. GLOSSARY

Term	Definition
Application Development Stage of Software Development	The stage of software development related to the enhancement or upgrade of in-house software, including the design of the chosen path, software configuration and interfaces, labor, installation to hardware, testing, and the parallel processing phase.
Asset	A tangible or intangible item of value.
Building	A structure that is permanently attached to the land, has a roof, is partially or completely enclosed by walls and is not intended to be transportable or moveable.
Capital	Capital refers to financial assets or the financial value of assets, in the form of money or other assets owned by an organization.
Capitalization Threshold	The threshold for capitalized items is five thousand ($5,000) dollars.
Capitalize	To record an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capitalization	The recording of an item as an asset rather than an expense such that the expenditure will appear in the balance sheet.
Capital Asset	Capital Asset: Any asset used in operations with an initial useful life extending beyond one (1) year that also meets the Capitalization Threshold.
Controllable Assets	Certain purchases that do not meet the criteria established for designation as a Capital asset, however, by their nature should be monitored for proper use and disposal. These controllable assets either render a critical function or put the organization at risk by their absence. Such items include but are not limited to laptops, computers, printers, minor furnishings, and general office equipment.
Cost	Cost includes freight, installation, taxes and other charges incurred to place the asset in use. Service and maintenance contracts are charged to prepaid expenses and amortized over the period of the contract.
Fixed Assets	Fixed assets or Capital assets are tangible assets with a value greater than or equal to the Capitalization Threshold and a useful life in excess of one (1) year. Fixed assets include buildings, machinery and equipment, computer equipment, vehicles, improvements, and land.
Internally Developed Software	Software developed in-house by personnel or by a third-party contractor on behalf of CalOptima or commercially available software purchased or licensed by CalOptima.
Preliminary Project Stage of Software Development	The stage of software development related to the internal development of software that is new to the organization. which includes design, configuration, interfaces, labor, installation, testing, and evaluations of alternatives.
Post-Implementation Project Stage of Software Development	All expenditures related to the post-implementation of internally developed software. Expenditures include application maintenance, labor, and training.
Straight-line Method	A method to record the allocation of an asset's cost evenly over its useful life.

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Summary: Capitalization Requirements by Project Development Stage

	Expense	Capitalize
I. Preliminary Project Stage Activities:		
Conceptual formulation of alternatives	x	
Evaluation of alternatives	x	
Determination of existence of needed technology	x	
Final selection of alternatives	x	
II. Application Development Stage Activities:		
Design of chosen path, including software configuration and interface		x
Coding		x
Installation to hardware		x
Testing, including parallel processing phase		x
Data Conversion Costs:		
a. Costs to develop/obtain software that allows access of old data by new system		x
b. All other data conversion processes	x	
Training	x	
III. Post-Implementation/Operation Stage Activities:		
Application maintenance	x	
Ongoing support	x	
Training	x	

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Adopt Board Resolution No. 22-0303-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with California Government Code section 54953, subdivision (e)

Contact

Michael Hunn, Interim Chief Executive Officer (657) 900-1481

Recommended Action

Adopt Board Resolution No. 22-0303-01, authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e).

Background

Under the Ralph M. Brown Act, California Government Code Section 54950 *et seq.*, (Brown Act) meetings of California local public bodies must be open and public. Prior to the COVID-19 pandemic, the Brown Act has generally allowed a local agency to use teleconferencing for public meetings, subject to specific agenda, posting, physical access, and quorum requirements. On March 4, 2020, pursuant to Government Code section 8625, Governor Gavin Newsom declared a state of emergency related to the COVID-19 pandemic. On November 10, 2021, Governor Newsom issued Executive Order N-21-21, extending the state of emergency through March 31, 2022, and the declaration of emergency continues in effect and has not been lifted or rescinded.

On March 17, 2020, Governor Newsom signed Executive Order N-29-20, suspending certain provisions of the Brown Act, including, in part, suspending the requirement for in-person legislative meetings and suspending the requirement that each teleconference location be accessible to the public. The Governor's Executive Order expired on September 30, 2021.

Under Assembly Bill (AB) 361, which was signed by Governor Newsom and took effect on September 16, 2021, the Brown Act was amended for a limited time to authorize local agencies to hold teleconference public meetings without complying with certain Brown Act requirements provided that certain conditions are met. These include:

> (A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing; or
>
> (B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees; or
>
> (C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

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If meetings are held via teleconference under these special circumstances, the legislative body must ensure that notice of the meetings are given and agendas posted, and that the rights of the public to observe and participate are protected (including delaying action on any items during any period where a disruption prevents the broadcasting of the meeting to the public and or the ability of the public to participate).

Discussion

Pursuant to the language of AB 361, in order for CalOptima to continue holding teleconference meetings, the Board is required to make the following findings by majority vote within 30 days of teleconferencing for the first time under AB 361 and every 30 days thereafter:

> (A) The legislative body has reconsidered the circumstances of the state of emergency.
> (B) Any of the following circumstances exist:
>> (i) The state of emergency continues to directly impact the ability of the members to meet safely in person; or
>> (ii) State or local officials continue to impose or recommend measures to promote social distancing.

Given the continued active declaration of emergency arising from the COVID-19 pandemic and the Governor's extension of the declaration of a state of emergency through March 31, 2022, there is an ongoing need for holding teleconference meetings for the CalOptima Board of Directors and its advisory committees. In addition, the County of Orange Health Officer issued "Orders and Strong Recommendations," updated as of January 14, 2022, to strongly recommend preventative measures such as avoiding gathering and practicing social distancing. For CalOptima to continue the teleconference meetings, the required finding are set forth in the attached Resolution No. 22-0303-01.

In addition, as part of the continued obligations to protect the public's right to participate in the meetings of local legislative bodies, CalOptima is also required to do the following:

- Allow the public to access the meeting and require that the agenda provide an opportunity for the public to directly address the legislative body pursuant to the Brown Act's other teleconferencing provisions.
- In each instance when CalOptima provides notice of the teleconferenced meeting or post its agenda, give notice for how the public can access the meeting and provide public comment.
- Identify and include in the agenda an opportunity for all persons to attend via a call-in or an internet-based service option.
- Conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the public.
- In the event of service disruption that either presents CalOptima from broadcasting the meeting to the public using the call-in or internet-based service option or a disruption within CalOptima's control that prevents the public from submitting public comments, stop the meeting until public access is restored.
- Not require comments be submitted in advance and provide the opportunity to comment in real time.

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- Provide adequate time for public comment, either by establishing a timed public comment period or by allowing a reasonable amount of time to comment, including the time that may be required for an individual to register to log in to the teleconference to provide public comment.

Fiscal Impact
The recommended action to adopt a resolution authorizing remote teleconference meetings for the CalOptima Board of Directors and its advisory committees in accordance with Government Code section 54953, subdivision (e), will have no fiscal impact on CalOptima.

Rationale for Recommendation
The recommended action to allow for teleconference meetings for the CalOptima Board of Directors and its advisory committees will satisfy the requirements of Government Code section 54953, subdivision (e) and allow CalOptima to hold public meetings via teleconference as the statute allows in a manner that will minimize the risks associated with the continuing public emergency related to the COVID-19 pandemic.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Board Resolution No. 22-0303-01, Authorizing Remote Teleconference Meetings for the CalOptima Board of Directors and its Advisory Committees in Accordance with Government Code section 54953, subdivision (e)
2. March 4, 2020, Proclamation of a State of Emergency
3. November 10, 2021, Extension of the State of Emergency
4. January 14, 2022, Orange County Health Officer's Orders and Strong Recommendations
5. Government Code section 54953, as amended by AB 361

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0303-01

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

AUTHORIZING REMOTE TELECONFERENCE MEETINGS FOR THE CALOPTIMA BOARD OF DIRECTORS AND ITS ADVISORY COMMITTEES IN ACCORDANCE WITH GOVERNMENT CODE SECTION 54953, SUBDIVISION (e)

WHEREAS, CalOptima is a local public agency created pursuant to Welfare and Institutions Code section 14087.54 by the County of Orange under Orange County Ordinance No. 3896, as amended, which established CalOptima as a separate and distinct public entity; and

WHEREAS, CalOptima is committed to compliance with the requirements of the Ralph M. Brown Act (Brown Act) to provide transparency, public access, and opportunities to participate in meetings of CalOptima's Board of Directors and its advisory committees.

WHEREAS, on March 4, 2020, pursuant to Government Code section 8625, the Governor of California declared a state of emergency in response to the COVID-19 pandemic; and

WHEREAS, on March 17, 2020, the Governor issued Executive Order N-29-20, which suspended certain requirements under the Brown Act and modified the teleconference requirements to allow legislative bodies of public agencies to hold public meetings via teleconference; and

WHEREAS, on June 4, 2021, the Governor clarified that the "reopening" of California on June 15, 2021, did not include any change to the declared state of emergency or the powers exercised thereunder; and

WHEREAS, on June 11, 2021, the Governor issued Executive Order N-08-21, which extended the provision of Executive Order N-29-20 concerning the conduct of public meetings through September 30, 2021; and

WHEREAS, California Assembly Bill (AB) 361 was signed into law effective September 16, 2021, which amended the teleconferencing requirement under the Brown Act provision in Government Code section 54953; and

WHEREAS, Government Code section 54953, subdivision (b)(3) permits public meetings by teleconference, but requires: the agendas to be posted at all teleconference locations; each teleconference location be identified in the notice and agenda of the meeting or proceeding; and each teleconference location be accessible to the public; and

WHREREAS, Government Code section 54953, subdivision (e) provides an alternative to having public meetings in accordance with Government Code section 54953, subdivision (b)(3) when the circumstances of the COVID-19 state of emergency and the following circumstances exist: (1) The state of emergency as a result of COVID-19 continues to directly impact the ability of members of CalOptima's Board of Directors and members of CalOptima committees to meet safely in person; and (2) the State of California and/or the County of Orange continue to impose or recommend measures to promote social distancing; and

WHEREAS, on November 10, 2021, the Governor extended the state of emergency through March 31, 2022; and

WHEREAS, as of the date of this Resolution, neither the Governor nor the Legislature have exercised their respective powers pursuant to California Government Code section 8629 to lift the state of emergency either by proclamation or by concurrent resolution of the state Legislature; and

WHEREAS, on January 14, 2022, the County of Orange Health Officer issued a revised "Orders and Strong Recommendations," which includes strong recommendations for preventative measures, such as avoiding gathering and practicing social distancing; and

WHEREAS, the continued local rates of transmission of the virus and variants causing COVID-19 are such that meeting in person could present imminent risks to the health or safety of attendees of CalOptima's public meetings if teleconference options are not included as an option for participation; and,

WHEREAS, the CalOptima Board of Directors and advisory committees have met remotely during the COVID-19 pandemic and can continue to do so in a manner that allows public participation and transparency while minimizing health risks to the Board members, staff, and public that would be present with in-person meetings while this state of emergency continues; and

WHEREAS, the Board of Directors has considered all information related to this matter and determined that it is in the best interest of the public and CalOptima that the Board of Directors meetings and advisory committee meetings of other CalOptima bodies be held via teleconference for the next thirty (30) days.

NOW, THEREFORE, BE IT RESOLVED:

I. That the CalOptima Board of Directors has duly considered the active status of the current state of emergency through March 31, 2022, along with the County of Orange Health Officer's strong recommendation to continue implementing COVID-19 preventative measures, such as social distancing, and has found that the state of emergency continues to directly impact the ability of the CalOptima Board of Directors and its advisory committees to meet safely in person,

II. That, as a result of the continued impact on the safety of the public and CalOptima officials, all CalOptima public meetings for the next thirty (30) days shall be conducted via teleconferencing, and such teleconferencing shall be carried out in compliance with California Government Code Section 54953, including, but not limited to, provisions protecting the statutory and constitutional rights of the public to attend and participate in such meetings.

III. That this Resolution shall take effect immediately upon its adoption and shall be effective until the earlier of (i) thirty (30) days after teleconferencing for the first time pursuant to Government Code section 54953(e), or (ii) such time that the CalOptima Board of Directors adopts a subsequent resolution in accordance with Government Code section 54953, subdivision (e)(3) to extend the time during which CalOptima's Board of Directors and advisory committees may continue to teleconference without compliance with Government Code section 54953, subdivision (e)(3)(b); and

IV. That the Chief Executive Officer of CalOptima is directed to place a resolution substantially similar to this resolution on the agenda of a future meeting of the CalOptima Board of Directors within the next thirty (30) days, or as soon thereafter as the CalOptima Board of Directors shall meet.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 3rd day of March, 2022.

AYES: _____

NOES: _____

ABSENT: _____

ABSTAIN: _____

/s/_____
Printed Name and Title: Andrew Do, Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

PROCLAMATION OF A STATE OF EMERGENCY

WHEREAS in December 2019, an outbreak of respiratory illness due to a novel coronavirus (a disease now known as COVID-19), was first identified in Wuhan City, Hubei Province, China, and has spread outside of China, impacting more than 75 countries, including the United States; and

WHEREAS the State of California has been working in close collaboration with the national Centers for Disease Control and Prevention (CDC), with the United States Health and Human Services Agency, and with local health departments since December 2019 to monitor and plan for the potential spread of COVID-19 to the United States; and

WHEREAS on January 23, 2020, the CDC activated its Emergency Response System to provide ongoing support for the response to COVID-19 across the country; and

WHEREAS on January 24, 2020, the California Department of Public Health activated its Medical and Health Coordination Center and on March 2, 2020, the Office of Emergency Services activated the State Operations Center to support and guide state and local actions to preserve public health; and

WHEREAS the California Department of Public Health has been in regular communication with hospitals, clinics and other health providers and has provided guidance to health facilities and providers regarding COVID-19; and

WHEREAS as of March 4, 2020, across the globe, there are more than 94,000 confirmed cases of COVID-19, tragically resulting in more than 3,000 deaths worldwide; and

WHEREAS as of March 4, 2020, there are 129 confirmed cases of COVID-19 in the United States, including 53 in California, and more than 9,400 Californians across 49 counties are in home monitoring based on possible travel-based exposure to the virus, and officials expect the number of cases in California, the United States, and worldwide to increase; and

WHEREAS for more than a decade California has had a robust pandemic influenza plan, supported local governments in the development of local plans, and required that state and local plans be regularly updated and exercised; and

WHEREAS California has a strong federal, state and local public health and health care delivery system that has effectively responded to prior events including the H1N1 influenza virus in 2009, and most recently Ebola; and

WHEREAS experts anticipate that while a high percentage of individuals affected by COVID-19 will experience mild flu-like symptoms, some will have more serious symptoms and require hospitalization, particularly individuals who are elderly or already have underlying chronic health conditions; and

WHEREAS it is imperative to prepare for and respond to suspected or confirmed COVID-19 cases in California, to implement measures to mitigate the spread of COVID-19, and to prepare to respond to an increasing number of individuals requiring medical care and hospitalization; and

WHEREAS if COVID-19 spreads in California at a rate comparable to the rate of spread in other countries, the number of persons requiring medical care may exceed locally available resources, and controlling outbreaks minimizes the risk to the public, maintains the health and safety of the people of California, and limits the spread of infection in our communities and within the healthcare delivery system; and

WHEREAS personal protective equipment (PPE) is not necessary for use by the general population but appropriate PPE is one of the most effective ways to preserve and protect California's healthcare workforce at this critical time and to prevent the spread of COVID-19 broadly; and

WHEREAS state and local health departments must use all available preventative measures to combat the spread of COVID-19, which will require access to services, personnel, equipment, facilities, and other resources, potentially including resources beyond those currently available, to prepare for and respond to any potential cases and the spread of the virus; and

WHEREAS I find that conditions of Government Code section 8558(b), relating to the declaration of a State of Emergency, have been met; and

WHEREAS I find that the conditions caused by COVID-19 are likely to require the combined forces of a mutual aid region or regions to appropriately respond; and

WHEREAS under the provisions of Government Code section 8625(c), I find that local authority is inadequate to cope with the threat posed by COVID-19; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes and regulations specified in this order would prevent, hinder, or delay appropriate actions to prevent and mitigate the effects of the COVID-19.

NOW, THEREFORE, I, GAVIN NEWSOM, Governor of the State of California, in accordance with the authority vested in me by the State Constitution and statutes, including the California Emergency Services Act, and in particular, Government Code section 8625, **HEREBY PROCLAIM A STATE OF EMERGENCY** to exist in California.

IT IS HEREBY ORDERED THAT:

1. In preparing for and responding to COVID-19, all agencies of the state government use and employ state personnel, equipment, and facilities or perform any and all activities consistent with the direction of the Office of Emergency Services and the State Emergency Plan, as well as the California Department of Public Health and the Emergency Medical Services Authority. Also, all residents are to heed the advice of emergency officials with regard to this emergency in order to protect their safety.

2. As necessary to assist local governments and for the protection of public health, state agencies shall enter into contracts to arrange for the procurement of materials, goods, and services needed to assist in preparing for, containing, responding to, mitigating the effects of, and recovering from the spread of COVID-19. Applicable provisions of the Government Code and the Public Contract Code, including but not limited to travel, advertising, and competitive bidding requirements, are suspended to the extent necessary to address the effects of COVID-19.

3. Any out-of-state personnel, including, but not limited to, medical personnel, entering California to assist in preparing for, responding to, mitigating the effects of, and recovering from COVID-19 shall be permitted to provide services in the same manner as prescribed in Government Code section 179.5, with respect to licensing and certification. Permission for any such individual rendering service is subject to the approval of the Director of the Emergency Medical Services Authority for medical personnel and the Director of the Office of Emergency Services for non-medical personnel and shall be in effect for a period of time not to exceed the duration of this emergency.

4. The time limitation set forth in Penal Code section 396, subdivision (b), prohibiting price gouging in time of emergency is hereby waived as it relates to emergency supplies and medical supplies. These price gouging protections shall be in effect through September 4, 2020.

5. Any state-owned properties that the Office of Emergency Services determines are suitable for use to assist in preparing for, responding to, mitigating the effects of, or recovering from COVID-19 shall be made available to the Office of Emergency Services for this purpose, notwithstanding any state or local law that would restrict, delay, or otherwise inhibit such use.

6. Any fairgrounds that the Office of Emergency Services determines are suitable to assist in preparing for, responding to, mitigating the effects of, or recovering from COVID-19 shall be made available to the Office of Emergency Services pursuant to the Emergency Services Act, Government Code section 8589. The Office of Emergency Services shall notify the fairgrounds of the intended use and can immediately use the fairgrounds without the fairground board of directors' approval, and

notwithstanding any state or local law that would restrict, delay, or otherwise inhibit such use.

7. The 30-day time period in Health and Safety Code section 101080, within which a local governing authority must renew a local health emergency, is hereby waived for the duration of this statewide emergency. Any such local health emergency will remain in effect until each local governing authority terminates its respective local health emergency.

8. The 60-day time period in Government Code section 8630, within which local government authorities must renew a local emergency, is hereby waived for the duration of this statewide emergency. Any local emergency proclaimed will remain in effect until each local governing authority terminates its respective local emergency.

9. The Office of Emergency Services shall provide assistance to local governments that have demonstrated extraordinary or disproportionate impacts from COVID-19, if appropriate and necessary, under the authority of the California Disaster Assistance Act, Government Code section 8680 et seq., and California Code of Regulations, Title 19, section 2900 et seq.

10. To ensure hospitals and other health facilities are able to adequately treat patients legally isolated as a result of COVID-19, the Director of the California Department of Public Health may waive any of the licensing requirements of Chapter 2 of Division 2 of the Health and Safety Code and accompanying regulations with respect to any hospital or health facility identified in Health and Safety Code section 1250. Any waiver shall include alternative measures that, under the circumstances, will allow the facilities to treat legally isolated patients while protecting public health and safety. Any facilities being granted a waiver shall be established and operated in accordance with the facility's required disaster and mass casualty plan. Any waivers granted pursuant to this paragraph shall be posted on the Department's website.

11. To support consistent practices across California, state departments, in coordination with the Office of Emergency Services, shall provide updated and specific guidance relating to preventing and mitigating COVID-19 to schools, employers, employees, first responders and community care facilities by no later than March 10, 2020.

12. To promptly respond for the protection of public health, state entities are, notwithstanding any other state or local law, authorized to share relevant medical information, limited to the patient's underlying health conditions, age, current condition, date of exposure, and possible contact tracing, as necessary to address the effect of the COVID-19 outbreak with state, local, federal, and nongovernmental partners, with such information to be used for the limited purposes of monitoring, investigation and control, and treatment and coordination of care. The

notification requirement of Civil Code section 1798.24, subdivision (i), is suspended.

13. Notwithstanding Health and Safety Code sections 1797.52 and 1797.218, during the course of this emergency, any EMT-P licensees shall have the authority to transport patients to medical facilities other than acute care hospitals when approved by the California EMS Authority. In order to carry out this order, to the extent that the provisions of Health and Safety Code sections 1797.52 and 1797.218 may prohibit EMT-P licensees from transporting patients to facilities other than acute care hospitals, those statutes are hereby suspended until the termination of this State of Emergency.

14. The Department of Social Services may, to the extent the Department deems necessary to respond to the threat of COVID-19, waive any provisions of the Health and Safety Code or Welfare and Institutions Code, and accompanying regulations, interim licensing standards, or other written policies or procedures with respect to the use, licensing, or approval of facilities or homes within the Department's jurisdiction set forth in the California Community Care Facilities Act (Health and Safety Code section 1500 et seq.), the California Child Day Care Facilities Act (Health and Safety Code section 1596.70 et seq.), and the California Residential Care Facilities for the Elderly Act (Health and Safety Code section 1569 et seq.). Any waivers granted pursuant to this paragraph shall be posted on the Department's website.

I FURTHER DIRECT that as soon as hereafter possible, this proclamation be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this proclamation.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 4th day of March 2020.

GAVIN NEWSOM
Governor of California

ATTEST:

ALEX PADILLA
Secretary of State

EXECUTIVE DEPARTMENT
STATE OF CALIFORNIA

EXECUTIVE ORDER N-21-21

WHEREAS on March 4, 2020, I proclaimed a State of Emergency to exist in California as a result of the threat of COVID-19; and

WHEREAS in response to the ongoing COVID-19 pandemic and increased spread of the Delta variant, on August 16, 2021, I issued Executive Order N-12-21 to ensure the State's health care facilities continue to have the staffing and resources needed to prevent potential strain on the State's health care delivery system; and

WHEREAS on October 4, 2021, I issued Executive Order N-17-21 to extend flexibilities allowing the State to increase health care capacity to support ongoing testing and vaccination efforts and minimize the threat of COVID-19 to Californians; and

WHEREAS California has stopped recording week-over-week declines in COVID-19 cases and hospitalizations, which demonstrates a plateau and the potential beginning of a new surge in COVID-19 cases; and

WHEREAS as flu season approaches, it is critical that California's health care facilities, already short-staffed and backlogged from the Delta variant and with high-levels of non-COVID-19 admissions, have the flexibilities that they need for additional capacity and to prevent staffing shortages; and

WHEREAS California continues to prioritize efforts to vaccinate all eligible individuals against COVID-19, including ensuring access to boosters and vaccines for newly eligible populations; and

WHEREAS supporting robust COVID-19 testing capacity remains critical in the efforts to protect public health and mitigate the impacts of the pandemic; and

WHEREAS continued flexibility in non-hospital settings remains necessary to support these ongoing testing and vaccination efforts and to minimize the threat of COVID-19 to vulnerable Californians; and

WHEREAS under the provisions of Government Code section 8571, I find that strict compliance with various statutes, regulations, and certain

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IT IS HEREBY ORDERED THAT:

1. The timeframes set forth in Executive Order N-12-21, paragraphs 1 through 6, are hereby extended through March 31, 2022.

2. The timeframe set forth in Executive Order N-17-21, Paragraph 1, is hereby extended through March 31, 2022.

I FURTHER DIRECT that as soon as hereafter possible, this Order be filed in the Office of the Secretary of State and that widespread publicity and notice be given of this Order.

This Order is not intended to, and does not, create any rights or benefits, substantive or procedural, enforceable at law or in equity, against the State of California, its agencies, departments, entities, officers, employees, or any other person.

IN WITNESS WHEREOF I have hereunto set my hand and caused the Great Seal of the State of California to be affixed this 10th day of November 2021.

GAVIN NEWSOM
Governor of California

ATTEST:

SHIRLEY WEBER, PH.D.
Secretary of State

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COUNTY OF ORANGE HEALTH OFFICER'S ORDERS AND STRONG RECOMMENDATIONS

(Revised January 14, 2022)

In light of the recent quarantine and isolation guidelines announced/issued by Centers for Disease Control and Preventions (CDC) and California Department of Public Health (CDPH), the following Orders and Strong Recommendations shall revise and replace the prior Orders and Strong Recommendations of the County Health Officer that were issued on January 4, 2022. The Orders and Strong Recommendations issued on January 4, 2022, are no longer in effect as of January 14, 2022.

Pursuant to California Health and Safety Code sections 101030, 101040, 101470, 120175, and 120130, the County Health Officer for County of Orange orders and strongly recommends the following:

ORDERS

Effective immediately, and continuing until further notice, the following shall be in effect in unincorporated and incorporated territories of Orange County, California:

I. Self-Isolation and Self-Quarantine Orders

NOTE: Refer to the Definition Section below for the meaning of terms used in this isolation and quarantine orders, e.g., exposure to COVID-19, symptoms, etc.

A. Self-isolation of Persons with COVID-19

NOTE: This self-isolation order DOES NOT in any way restrict access by first responders to an isolation site during an emergency.

1. Persons who test positive for COVID-19. Persons who test positive for COVID-19 shall immediately isolate themselves in their home or another suitable place for at least 5 days. They may discontinue self-isolation after day 5 from the date they test positive IF:

    - COVID-19 symptoms are not present and a diagnostic specimen collected on day 5 or later tests negative.

        - An antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, however, if it is recommended that persons use an antigen test for ending isolation. Use of Over-the-Counter tests are also acceptable to end isolation.

    - If unable to test, choose not to test, or test positive by repeat testing, and symptoms are not present or not resolving, isolation shall continue through day 10 and may end after 10 days regardless of whether symptoms are present or resolving.

    - They should continue to wear a well-fitting mask at all times around other people through at least day 10.

2. Persons who have symptoms. Persons who have COVID-19 symptomatic shall immediately isolate themselves in their home or another suitable place for 5 days from the date of their symptom onset. They may end isolation IF:

    - A diagnostic specimen collected as early as the onset of their symptoms or later tests negative.

        - An antigen test, nucleic acid amplification test (NAAT), or LAMP test are acceptable, however, if it is recommended that persons use an antigen test for ending isolation. Use of Over-the-Counter tests are also acceptable to end isolation.

- If fever is present, isolation shall continue until fever resolves without the use of fever-reducing medications.
- If symptoms other than fever are not resolving, isolation shall continue (i) until symptoms are resolving or (ii) for 10 days regardless of whether symptoms are resolving or not.
- If unable to test, choose not to test, or test positive by repeat testing, and symptoms are not present or not resolving, isolation shall continue through day 10 and may end after 10 days regardless of whether symptoms are present or resolving.
- They should continue to wear a well-fitting mask at all times around other people through at least day 10.

3. Additional Considerations for Self-Isolation.

   - A person who is self-isolated may not leave his or her place of isolation except to receive necessary medical care.
   - If a more specific and individualized isolation order is issued by the County Health Officer for any county resident, the resident shall follow the specific order instead of the order herein.
   - People who are severely ill with COVID-19 might need to stay in self-isolation longer than 5 days and up to 20 days after symptoms first appeared. People with weakened immune systems should talk to their healthcare provider for more information.

B. Exemption from Isolation

- Health care providers who (i) work at general acute care hospitals, acute psychiatric hospitals, and skilled nursing facilities; (ii) have tested positive for COVID-19; and (iii) do not have any symptoms are not required to isolate per this Order. This exemption is effective through February 1, 2022. They shall wear an N95 respirator for source control. Facilities implementing this exemption (i) must have made every attempt to bring in additional registry or contract staff and must have considered

modifications to non-essential procedures; and (ii) should preferably assign them to work with COVID-19 positive patients.

C. Self-Quarantine of Persons Exposed to COVID-19

NOTE: The self-quarantine orders and exemptions below DO NOT in any way restrict access by first responders to a quarantine site during an emergency.

1. Not-up-to-date personas. Persons who (i) do not have symptoms; (ii) are not-up-to-date with COVID-19 vaccination; and (iii) know they have been exposed to COVID-19 shall quarantine for at least 5 days after their most recent exposure to COVID-19. Self-quarantine may end after day 5 IF:

   - Person has not developed any symptoms and a diagnostic specimen collected on day 5 or later tests negative.
     - Use of Over-the-Counter tests are acceptable to end quarantine.
   - If the person is unable to test or chooses not to test, s/he shall quarantine for 10 days after most recent exposure to COVID-19.
   - Additionally, the person should continue to wear a well-fitting mask around other people through at least day 10 after most recent exposure to COVID-19.

D. Exemptions from Quarantine

1. Asymptomatic up-to-date persons. Persons who (i) are up-to-date with COVID-19 vaccinations prior to their exposure to COVID-19; and (ii) have not developed any symptoms since their exposure to COVID-19 are not required to quarantine.

   - They should test on day 5 from date of exposure to COVID-19. If they test positive, they shall immediately self-isolate, as ordered above, and contact their healthcare provider with any questions regarding their care.
   - They should continue to wear a well-fitting mask at all times around other people through at least day 10 after their exposure to COVID-19.

2. Asymptomatic persons previously infected. Persons who (i) are exposed to COVIV-19; (ii) test positive for COVID-19 before their new, recent exposure to COVID-19; and (iii) it has been less than 3 months since they started having

symptoms from that previous infection (or since their first positive COVID-19 test if asymptomatic), are not required to quarantine per this Order, as long as they have not had any new symptoms since their recent exposure to COVID-19.

3. Exposed Asymptomatic Emergency Responders and Health Care Workers. During critical staffing shortages, exposed emergency responders and health care workers who do not have any symptoms are not required to quarantine. They should wear a well-fitting mask at all times when around others for at least 10 days after their most recent exposure to COVID-19 and monitor for symptoms of COVID-19.

4. Non-health care provider and non-emergency workers. All non-health care provider and non-emergency responder workers (i) who are fully vaccinated and eligible for a booster shot but have not yet obtained their booster shot; and (ii) who do not have symptoms are not required to quarantine per this Order if:

   - A diagnostic specimen collected on day 5 or later tests negative (use of Over-the-Counter tests are acceptable); and
   - The worker wears a well-fitting mask around others for 10 days from date of last exposure to COVID-19; and
   - The worker does not develop any symptoms.

5. Quarantine of Students in both Private and Public Transitional Kindergarten through Grade 12. Schools/school districts may choose from between the following two models for students who are exposed to COVID-19:

   Option 1. Individual Management – Students in both private and public transitional kindergarten through grade 12 shall follow the isolation and self-quarantine orders above with the following Modified Quarantine exemption:

   Modified Quarantine. If a not-up-to-date student is exposed to COVID-19 and both were wearing mask then the exposed student may continue to attend school for in-person instruction during the duration of his or her quarantine period if the following conditions are met:

   - The exposed student does not develop any symptoms; AND

- The exposed student continues to appropriately wear well-fitting mask; AND
- The exposed student undergoes testing for COVID-19 at least twice during the 5 days quarantine period (use of Over-the-Counter tests are acceptable); AND
- The exposed student refrains from participation in all extracurricular activities at school, including sports, and activities within the community setting for the duration of his or her quarantine period. The exposed student may participate in all required instructional components of the school day, except activities where a mask cannot be worn, such as while playing certain musical instruments. The exposed student may also eat meals on campus.
- If the exposed student is unable to test or chooses not to test, s/he shall quarantine for 10 days after most recent exposure to COVID-19.

Option 2. Group Tracing Approach – For this option, schools will notify groups of students. Groups of students mean those students who spent more than 15 minutes (over a 24-hour period) in the same indoor airspace (e.g., classroom) with someone who has COVID-19, regardless of their vaccination status or previous COVID-19 disease. Notification would be to groups of exposed students (e.g., classmates, teammates, cohorts) rather than the individual students identified in Option 1 (Individual Management), above. The notification will provide the following information:

- Exposure to COVID-19;
- Last known date of exposure to COVID-19;
- The option to continue to attend school so long as they are free of any symptoms (those who develop symptoms shall isolate per the isolation order, above);

- Recommendation to undergo testing 3 to 5 days after most recent exposure to COVID-19;
- Shall wear a well-fitting mask;
- If unable to wear a mask due to a documented exemption the student must quarantine at home until the student has obtained a negative result for the test administered on day 3 to 5 after most recent exposure to COVID-19.
- Students so notified who participate in activities where it is not practicable to participate with a mask on will refrain from that activity until negative results is obtained from the test administered on day 3 to -5 after most recent last exposure to COVID-19. If they are participating in routine testing program, at least once per week they may continue with all activities, so long as they remain asymptomatic and test negative.

In the event of wide-scale and or repeated exposures, broader (grade-wide or campus-wide) once weekly testing for COVID-19 may be chosen in lieu of group notification until such time as exposure events become less frequent.

E. Definitions

The following definitions shall govern the meaning of terms in the isolation and quarantine orders, above.

1. *Symptom(s)*. Whenever the term "symptom" is used, it shall mean COVID-19 symptom. People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these symptoms may have COVID-19:
    - Fever or chills
    - Cough
    - Shortness of breath or difficulty breathing
    - Fatigue

- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

The list above does not include all possible symptoms.

2. *Up-to-date with COVID-19 vaccination*. Persons 12 years and older are considered up-to-date with their COVID-19 vaccination if they have completed a primary series of COVID-19 vaccine and have either received a booster shot or are not yet recommended to receive a booster dose according to current CDC guidance. Those less than 12 years of age are considered up-to-date with their COVID-19 Vaccinations if they have completed their primary series according to CDC guidance:

   CDC COVID-19 Primary Vaccine Series Guidance

   CDC COVID-19 Vaccine Booster Shot Guidance

3. *Not-up-to-date with COVID-19 vaccination*. All persons who do not meet the criteria under up-to-date with COVID-19 vaccination, as defined above, are considered not-up-to-date with their COVID-19 vaccination.

4. *Exposed to COVID-19 or exposure to COVID-19*. These terms mean to be within 6 feet of someone who has COVID-19 for a cumulative total of 15 minutes or more over a 24-hour period.

5. *Emergency responder*. This term includes military or national guard, law enforcement officers, correctional institution personnel, fire fighters, emergency medical services personnel, physicians, nurses, public health personnel, emergency medical technicians, paramedics, emergency

management personnel, 911 operators, child welfare workers and service providers, public works personnel, and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency, as well as individuals who work for such facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

6. *Health care provider*. This term includes physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

II. Face-Covering Order:

- **Wear a Cloth Face-Covering**. To help prevent the spread of droplets containing COVID-19, all County residents and visitors shall wear face coverings in accordance with and as required by the Guidance for the Use of Face Coverings issued by CDPH, effective December 15, 2021. The Guidance is attached herein as Attachment "**A**" and can be found at:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx.

The Guidance orders, as follows:

Masking Requirements.

Masks are required for all individuals in all indoor public settings, regardless of vaccination status from December 15, 2021, through February 15, 2022. Full guidance can be found at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx.

In workplaces, employers are subject to the Cal/OSHA COVID-19 Emergency Temporary Standards (ETS) or in some workplaces the Cal/OSHA Aerosol Transmissible Diseases (ATD) Standard and should consult those regulations for additional applicable requirements.

See State Health Officer Order, issued on July 26, 2021 (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx), for a full list of high-risk congregate and other healthcare settings where surgical masks are required for unvaccinated workers, and recommendations for respirator use for unvaccinated workers in healthcare and long-term care facilities in situations or settings not covered by Cal OSHA ETS or ATD.

No person can be prevented from wearing a mask as a condition of participation in an activity or entry into a business.

Exemptions to masks requirements.

The following individuals are exempt from wearing masks at all times:

- Persons younger than two years old. Very young children must not wear a mask because of the risk of suffocation.
- Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition

for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.

- Persons who are hearing impaired, or communicating with a person who is hearing impaired, where the ability to see the mouth is essential for communication.
- Persons for whom wearing a mask would create a risk to the person related to their work, as determined by local, state, or federal regulators or workplace safety guidelines.

The County Health Officer strongly recommends that all mask wearers consistently and correctly wear a mask that offers good filtration to get the best protection. To improve efficacy, the mask should fit to minimize gaps between the face and mask. The mask should also fully cover the nose and mouth. If wearing a fabric face covering, three layers should be worn to offer better filtration.

The County Health Officer also strongly recommends wearing a face shield for members of the public who cannot wear a face covering due to a medical condition or other exemption (except for children younger than 2 years old), although they may not work as well as face coverings in their ability to prevent the spread of COVID-19 to others. A cloth “drape” should be attached to the bottom edge of the face shield and tucked into the shirt to minimize gaps between the face and face shield.

III. Vaccination and Testing for COVID-19 Orders:

1. **COVID-19 Vaccination for Workers and Service Providers of Certain Facilities**. To help prevent transmission of COVID-19, all workers who provide services or work in facilities described below shall comply with the COVID-19 vaccination and booster dose requirements as set forth in the December 22, 2021, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**B**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

Facilities covered by this order include:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities
- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

The word, "worker," as used in this Order shall have the same meaning as defined in the State Health Officer's Order, dated December 22, 2021. *See* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

2. **Requirements for COVID-19 Vaccination Status Verification, COVID-19 Testing, and Masking for Certain Facilities**.

To help prevent transmission of COVID-19, all facilities described below shall comply with the State Health Officer Order, effective August 9, 2021. A copy of the State Health Officer Order is attached herein as Attachment "**C**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Unvaccinated-Workers-In-High-Risk-Settings.aspx

Facilities covered by this order include:

Acute Health Care and Long-Term Care Settings:

- General Acute Care Hospitals
- Skilled Nursing Facilities (including Subacute Facilities)
- Intermediate Care Facilities

High-Risk Congregate Settings:

- Adult and Senior Care Facilities
- Homeless Shelters
- State and Local Correctional Facilities and Detention Centers

Other Health Care Settings:

- Acute Psychiatric Hospitals
- Adult Day Health Care Centers
- Adult Day Programs Licensed by the California Department of Social Services
- Program of All-Inclusive Care for the Elderly (PACE) and PACE Centers
- Ambulatory Surgery Centers
- Chemical Dependency Recovery Hospitals
- Clinics & Doctor Offices (including behavioral health, surgical)
- Congregate Living Health Facilities

- Dental Offices
- Dialysis Centers
- Hospice Facilities
- Pediatric Day Health and Respite Care Facilities
- Residential Substance Use Treatment and Mental Health Treatment Facilities

3. **Requirements for COVID-19 Vaccine Status Verification and COVID-19 Testing for School Workers in Transitional Kindergarten through Grade 12**. To prevent the further spread of COVID-19 in K-12 school settings, all public and private schools serving students in transitional kindergarten through grade 12 shall comply with the State Health Officer Order, effective August 12, 2021, regarding verification of COVID-19 vaccination status and COVID-19 testing of all workers. A copy of the State Health Officer Order is attached herein as Attachment "**D**" and can be found at the following link:

   https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Vaccine-Verification-for-Workers-in-Schools.aspx

   This Order does not apply to (i) home schools, (ii) child care settings, or (iii) higher education.

4. **Local Correctional Facilities and Detention Centers Health Care Worker Vaccination Requirement**.

   To prevent the further spread of COVID-19 in local correctional facilities and detention centers, all individuals identified in the State Health Officer Order, effective December 22, 2021, shall comply with the State Health Officer's Order with regards to obtaining COVID-19 vaccination and booster doses. A copy of the State Health Officer Order is attached herein as Attachment "**E**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

5. **Adult Care Facilities and Direct Care Worker Vaccination Requirements.**

To help prevent transmission of COVID-19, all individuals specified below shall comply with the COVID-19 vaccination and booster does requirements as set forth in the December 22, 2021, State Health Officer Order. A copy of the State Health Officer Order is attached herein as Attachment "**F**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Adult-Care-Facilities-and-Direct-Care-Worker-Vaccine-Requirement.aspx

Individuals covered by this order include:

- All workers who provide services or work in Adult and Senior Care Facilities licensed by the California Department of Social Services;
- All in-home direct care services workers, including registered home care aides and certified home health aides, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services;
- All waiver personal care services (WPCS) providers, as defined by the California Department of Health Care Services, and in-home supportive services (IHSS) providers, as defined by the California Department of Social Services, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services;
- All hospice workers who are providing services in the home or in a licensed facility; and
- All regional center employees, as well as service provider workers, who provide services to a consumer through the network of Regional Centers

serving individuals with developmental and intellectual disabilities, except for those workers who only provide services to a recipient with whom they live or who are a family member of the recipient for whom they provide services.

IV. Visiting Acute Health Care and Long-Term Care Setting Order:

Requirements for Visiting Acute Health Care and Long-Term Care Settings.

To help prevent transmission of COVID-19, all acute health care and long-term care settings shall comply with the indoor visitation requirements set forth in the State Health Officer, effective January 7, 2022 through February 7, 2022. A copy of the State Health Officer Order is attached herein as Attachment "**G**" and can be found at the following link:

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Requirements-for-Visitors-in-Acute-Health-Care-and-Long-Term-Care-Settings.aspx

V. Seasonal Flu Vaccination Order:

Seasonal Flu Vaccination for Certain County Residents.

All individuals who reside or work in Orange County and fall under one of the following categories, shall obtain the seasonal flu vaccination unless a medical or religious exemption applies: (i) current providers for congregate settings; (ii) current health care providers; and (iii) current emergency responders. However, nothing herein shall be construed as an obligation, on the part of employers, public or private, to require employees obtain the seasonal flu vaccination as a term or condition of employment.

- *Emergency responder* shall mean military or national guard; law enforcement officers; correctional institution personnel; fire fighters; emergency medical services personnel; physicians; nurses; public health personnel; emergency medical technicians; paramedics; emergency management personnel; 911 operators; child welfare workers and service providers; public works personnel; and persons with skills or training in operating specialized equipment or other skills needed to provide aid in a declared emergency; as well as individuals who work for such

facilities employing these individuals and whose work is necessary to maintain the operation of the facility.

- *Health care provider* shall mean physicians; psychiatrists; nurses; nurse practitioners; nurse assistants; medical technicians; any other person who is employed to provide diagnostic services, preventive services, treatment services or other services that are integrated with and necessary to the provision of patient care and, if not provided, would adversely impact patient care; and employees who directly assist or are supervised by a direct provider of diagnostic, preventive, treatment, or other patient care services; and employees who do not provide direct heath care services to a patient but are otherwise integrated into and necessary to the provision those services – for example, a laboratory technician who processes medical test results to aid in the diagnosis and treatment of a health condition. A person is not a health care provider merely because his or her employer provides health care services or because he or she provides a service that affects the provision of health care services. For example, IT professionals, building maintenance staff, human resources personnel, cooks, food services workers, records managers, consultants, and billers are not health care providers, even if they work at a hospital of a similar health care facility.

STRONG RECOMMENDATIONS

Effective immediately, and continuing until further notice, the following shall be in effect in unincorporated and incorporated territories in Orange County, California:

1. **For Vulnerable Populations**. In general, the older a person is, the more health conditions a person has, and the more severe the conditions, the more important it is to take preventive measures for COVID-19 such as getting vaccinated, including boosters, social distancing and wearing a mask when around people who don't live in the same household, and practicing hand hygiene. For more information see https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html.

2. **COVID-19 Vaccination for County Residents**. All Orange County residents should receive COVID-19 vaccination in accordance with the Federal Food and Drug

Administration (FDA) and CDC guidance unless a medical contraindication applies. Minors, who are eligible to receive COVID-19 vaccination in accordance with the applicable CDC guidelines, should be vaccinated in the presence of their parent or legal guardian.

3. **Seasonal Flu Vaccination for County Residents**. All County residents who are six months of age or older should obtain the seasonal flu vaccination unless a medical or religious exemption applies.

4. **COVID-19 Vaccination and Testing for Emergency Medical Technicians, Paramedics and Home Healthcare Providers**. To help prevent transmission of COVID-19, it is strongly recommended that all Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) are fully vaccinated by September 30, 2021.

   Furthermore, it is strongly recommended that all unvaccinated Emergency Medical Technicians, Paramedics, and Home Healthcare Providers (including In Home Supportive Services Program workers) undergo at least twice weekly testing for COVID-19 until such time they are fully vaccinated.

GENERAL PROVISIONS

1. The Orders and Strong Recommendations, above, shall not supersede any conflicting or more restrictive orders issued by the State of California or federal government. If any portion of this document or the application thereof to any person or circumstance is held to be invalid, the remainder of the document, including the application of such part or provision to other persons or circumstances, shall not be affected and shall continue in full force and effect. To this end, the provisions of the orders and strong recommendations are severable.

2. The Orders contained in this document may be enforced by the Orange County Sheriff or Chiefs of Police pursuant to California Health and Safety Code section 101029, and California Government Code sections 26602 and 41601. A violation of a health order is subject to fine, imprisonment, or both (California Health and Safety Code section 120295).

REASONS FOR THE ORDERS AND STRONG RECOMMENDATIONS

1. On February 26, 2020, the County of Orange Health Officer declared a Local Health Emergency based on an imminent and proximate threat to public health from the introduction of COVID-19 in Orange County.

2. On February 26, 2020, the Chairwoman of the Board of Supervisors, acting as the Chair of Emergency Management Council, proclaimed a Local Emergency in that the imminent and proximate threat to public health from the introduction of COVID-19 created conditions of extreme peril to the safety of persons and property within the territorial limits of Orange County.

3. On March 2, 2020, the Orange County Board of Supervisors adopted Resolutions No. 20-011 and No. 20-012 ratifying the Local Health Emergency and Local Emergency, referenced above.

4. On March 4, 2020, the Governor of the State of California declared a State of Emergency to exist in California as a result of the threat of COVID-19.

5. As of January 14, 2022, the County has reported a total of 430,675 recorded confirmed COVID-19 cases and 5,921 of COVID-19 related deaths.

6. Safe and effective authorized COVID-19 vaccines are recommended by the CDC. According to CDC, anyone infected with COVID-19 can spread it, even if they do NOT have symptoms. The novel coronavirus is spread in 3 ways:1) Breathing in air when close to an infected person who is exhaling small droplets and particles that contain the virus. 2) Having these small droplets and particles that contain virus land on the eyes, nose, or mouth, especially through splashes and sprays like a cough or sneeze. 3) Touching eyes, nose, or mouth with hands that have the virus on them. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-covid-spreads.html.

7. CDC requires face coverings on planes, buses, trains, and other forms of public transportation traveling into, within, or out of the United States and in U.S. transportation

hubs such as airports and stations. See https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/about-face-coverings.html.

8. The CDPH issued a revised Guidance for the Use of Face Coverings, effective December 15, 2021, available at: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

9. According to the CDC and CDPH, older adults, individuals with medical conditions, and pregnant and recently pregnant persons are at higher risk of severe illness when they contract COVID-19. See https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/index.html; see also https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/PublicHealthGuidanceSelfIsolationforOlderAdultsandThoseWhoHaveElevatedRisk.aspx.

10. The Orders and the Strong Recommendations contained in this document are based on the following facts, in addition to the facts stated under the foregoing paragraphs: (i) Safe and effective FDA authorized COVID-19 vaccines have become widely available, but many Orange County residents have not yet had the opportunity to be vaccinated, or have not completed their vaccination series to be fully vaccinated; (ii) there are currently limited therapeutic options proven effective that consistently prevents the severe illness associated with COVID-19; (iii) the current consensus among public health officials for slowing down the transmission of and avoiding contracting COVID-19 is for unvaccinated persons to avoid gathering and practice social distancing, frequently wash hands with soap, wearing face covering and get vaccinated; (iv) some individuals who contract COVID-19 have no symptoms or have only mild symptoms and so are unaware that they carry the virus and are transmitting it to others; (v) current evidence shows that the novel coronavirus can survive on surfaces and can be indirectly transmitted between individuals; (vi) older adults and individuals with medical conditions are at higher risk of severe illness; (vii) sustained COVID-19 community transmission continues to occur; (viii) the age, condition, and health of a significant portion of Orange County's residents place them at risk for serious health complications, including hospitalization and death, from COVID-19; (ix) younger and otherwise healthy people are also at risk for serious negative health outcomes and for transmitting the novel coronavirus to others.

11. The orders and strong recommendations contained in this document are necessary and less restrictive preventive measures to control and reduce the spread of COVID-19 in Orange County, help preserve critical and limited healthcare capacity in Orange County and save the lives of Orange County residents.

12. The California Health and Safety Code section 120175 requires the County of Orange Health Officer knowing or having reason to believe that any case of a communicable disease exists or has recently existed within the County to take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases.

13. The California Health and Safety Code sections 101030 and 101470 require the county health officer to enforce and observe in the unincorporated territory of the county and within the city boundaries located with a county all of the following: (a) Orders and ordinances of the board of supervisors, pertaining to the public health and sanitary matters; (b) Orders, including quarantine and other regulations, prescribed by the department; and (c) Statutes relating to public health.

14. The California Health and Safety Code section 101040 authorizes the County of Orange Health Officer to take any preventive measure that may be necessary to protect and preserve the public health from any public health hazard during any "state of war emergency," "state of emergency," or "local emergency," as defined by Section 8558 of the Government Code, within his or her jurisdiction. "Preventive measure" means abatement, correction, removal, or any other protective step that may be taken against any public health hazard that is caused by a disaster and affects the public health.

15. The California Health and Safety Code section 120130 (d) authorizes the County of Orange Health Officer to require strict or modified isolation, or quarantine, for any case of contagious, infectious, or communicable disease, when such action is necessary for the protection of the public health.

IT IS SO ORDERED:

Date: January 12, 2022

Clayton Chau MD, PhD
County Health Officer
County of Orange

GOVERNMENT CODE - GOV

TITLE 5. LOCAL AGENCIES [50001 - 57607] *(Title 5 added by Stats. 1949, Ch. 81.)*
DIVISION 2. CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 55821] *(Division 2 added by Stats. 1949, Ch. 81.)*
PART 1. POWERS AND DUTIES COMMON TO CITIES, COUNTIES, AND OTHER AGENCIES [53000 - 54999.7] *(Part 1 added by Stats. 1949, Ch. 81.)*

CHAPTER 9. Meetings [54950 - 54963] *(Chapter 9 added by Stats. 1953, Ch. 1588.)*

54953. (a) All meetings of the legislative body of a local agency shall be open and public, and all persons shall be permitted to attend any meeting of the legislative body of a local agency, except as otherwise provided in this chapter.

(b) (1) Notwithstanding any other provision of law, the legislative body of a local agency may use teleconferencing for the benefit of the public and the legislative body of a local agency in connection with any meeting or proceeding authorized by law. The teleconferenced meeting or proceeding shall comply with all otherwise applicable requirements of this chapter and all otherwise applicable provisions of law relating to a specific type of meeting or proceeding.

(2) Teleconferencing, as authorized by this section, may be used for all purposes in connection with any meeting within the subject matter jurisdiction of the legislative body. All votes taken during a teleconferenced meeting shall be by rollcall.

(3) If the legislative body of a local agency elects to use teleconferencing, it shall post agendas at all teleconference locations and conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties or the public appearing before the legislative body of a local agency. Each teleconference location shall be identified in the notice and agenda of the meeting or proceeding, and each teleconference location shall be accessible to the public. During the teleconference, at least a quorum of the members of the legislative body shall participate from locations within the boundaries of the territory over which the local agency exercises jurisdiction, except as provided in subdivisions (d) and (e). The agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3 at each teleconference location.

(4) For the purposes of this section, “teleconference” means a meeting of a legislative body, the members of which are in different locations, connected by electronic means, through either audio or video, or both. Nothing in this section shall prohibit a local agency from providing the public with additional teleconference locations.

(c) (1) No legislative body shall take action by secret ballot, whether preliminary or final.

(2) The legislative body of a local agency shall publicly report any action taken and the vote or abstention on that action of each member present for the action.

(3) Prior to taking final action, the legislative body shall orally report a summary of a recommendation for a final action on the salaries, salary schedules, or compensation paid in the form of fringe benefits of a local agency executive, as defined in subdivision (d) of Section 3511.1, during the open meeting in which the final action is to be taken. This paragraph shall not affect the public’s right under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1) to inspect or copy records created or received in the process of developing the recommendation.

(d) (1) Notwithstanding the provisions relating to a quorum in paragraph (3) of subdivision (b), if a health authority conducts a teleconference meeting, members who are outside the jurisdiction of the authority may be counted toward the establishment of a quorum when participating in the teleconference if at least 50 percent of the number of members that would establish a quorum are present within the boundaries of the territory over which the authority exercises jurisdiction, and the health authority provides a teleconference number, and associated access codes, if any, that allows any person to call in to participate in the meeting and the number and access codes are identified in the notice and agenda of the meeting.

(2) Nothing in this subdivision shall be construed as discouraging health authority members from regularly meeting at a common physical site within the jurisdiction of the authority or from using teleconference locations within or near the jurisdiction of the authority. A teleconference meeting for which a quorum is established pursuant to this subdivision shall be subject to all other requirements of this section.

(3) For purposes of this subdivision, a health authority means any entity created pursuant to Sections 14018.7, 14087.31, 14087.35, 14087.36, 14087.38, and 14087.9605 of the Welfare and Institutions Code, any joint powers authority created pursuant to Article 1 (commencing with Section 6500) of Chapter 5 of Division 7 for the purpose of contracting pursuant to Section 14087.3 of the Welfare and Institutions Code, and any advisory committee to a county-sponsored health plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the advisory committee has 12 or more members.

(e) (1) A local agency may use teleconferencing without complying with the requirements of paragraph (3) of subdivision (b) if the legislative body complies with the requirements of paragraph (2) of this subdivision in any of the following circumstances:

(A) The legislative body holds a meeting during a proclaimed state of emergency, and state or local officials have imposed or recommended measures to promote social distancing.

(B) The legislative body holds a meeting during a proclaimed state of emergency for the purpose of determining, by majority vote, whether as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(C) The legislative body holds a meeting during a proclaimed state of emergency and has determined, by majority vote, pursuant to subparagraph (B), that, as a result of the emergency, meeting in person would present imminent risks to the health or safety of attendees.

(2) A legislative body that holds a meeting pursuant to this subdivision shall do all of the following:

(A) The legislative body shall give notice of the meeting and post agendas as otherwise required by this chapter.

(B) The legislative body shall allow members of the public to access the meeting and the agenda shall provide an opportunity for members of the public to address the legislative body directly pursuant to Section 54954.3. In each instance in which notice of the time of the teleconferenced meeting is otherwise given or the agenda for the meeting is otherwise posted, the legislative body shall also give notice of the means by which members of the public may access the meeting and offer public comment. The agenda shall identify and include an opportunity for all persons to attend via a call-in option or an internet-based service option. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(C) The legislative body shall conduct teleconference meetings in a manner that protects the statutory and constitutional rights of the parties and the public appearing before the legislative body of a local agency.

(D) In the event of a disruption which prevents the public agency from broadcasting the meeting to members of the public using the call-in option or internet-based service option, or in the event of a disruption within the local agency's control which prevents members of the public from offering public comments using the call-in option or internet-based

service option is restored. Actions taken on agenda items during a disruption which prevents the public agency from broadcasting the meeting may be challenged pursuant to Section 54960.1.

(E) The legislative body shall not require public comments to be submitted in advance of the meeting and must provide an opportunity for the public to address the legislative body and offer comment in real time. This subparagraph shall not be construed to require the legislative body to provide a physical location from which the public may attend or comment.

(F) Notwithstanding Section 54953.3, an individual desiring to provide public comment through the use of an internet website, or other online platform, not under the control of the local legislative body, that requires registration to log in to a teleconference may be required to register as required by the third-party internet website or online platform to participate.

(G) (i) A legislative body that provides a timed public comment period for each agenda item shall not close the public comment period for the agenda item, or the opportunity to register, pursuant to subparagraph (F), to provide public comment until that timed public comment period has elapsed.

(ii) A legislative body that does not provide a timed public comment period, but takes public comment separately on each agenda item, shall allow a reasonable amount of time per agenda item to allow public members the opportunity to provide public comment, including time for members of the public to register pursuant to subparagraph (F), or otherwise be recognized for the purpose of providing public comment.

(iii) A legislative body that provides a timed general public comment period that does not correspond to a specific agenda item shall not close the public comment period or the opportunity to register, pursuant to subparagraph (F), until the timed general public comment period has elapsed.

(3) If a state of emergency remains active, or state or local officials have imposed or recommended measures to promote social distancing, in order to continue to teleconference without compliance with paragraph (3) of subdivision (b), the legislative body shall, not later than 30 days after teleconferencing for the first time pursuant to subparagraph (A), (B), or (C) of paragraph (1), and every 30 days thereafter, make the following findings by majority vote:

(A) The legislative body has reconsidered the circumstances of the state of emergency.

(B) Any of the following circumstances exist:

(i) The state of emergency continues to directly impact the ability of the members to meet safely in person.

(ii) State or local officials continue to impose or recommend measures to promote social distancing.

(4) For the purposes of this subdivision, “state of emergency” means a state of emergency proclaimed pursuant to Section 8625 of the California Emergency Services Act (Article 1 (commencing with Section 8550) of Chapter 7 of Division 1 of Title 2).

(f) This section shall remain in effect only until January 1, 2024, and as of that date is repealed.

(Amended by Stats. 2021, Ch. 165, Sec. 3. (AB 361) Effective September 16, 2021. Repealed as of January 1, 2024, by its own provisions. See later operative version added by Sec. 4 of Stats. 2021, Ch. 165.)

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Ratify an Amendment to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services (DHCS) Related to Rate Changes

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Ratify Amendment to CalOptima's Primary Agreement between CalOptima and the DHCS related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima contracts with the 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 the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the agreement through December 31, 2022. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to ensure that the Medi-Cal members DHCS assigns to CalOptima have access to covered health care services.

Discussion

On January 24, 2022, DHCS requested that CalOptima sign and return the CY 2022 CCI Full Dual Rates Agreement Amendment as soon as possible, but no later than Friday, February 18, 2022. In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on Thursday, February 3, 2022, and returned the signed agreement amendment to DHCS. As such, staff requests the CalOptima Board of Directors' ratification of the Board Chair's execution of the CY 2022 CCI Full Dual rates agreement amendment with the DHCS.

Rate Changes

DHCS's agreement amendment incorporates rates related to CCI Full Dual rates for the period of January 1, 2022, through December 31, 2022.

CY 2022 CCI Full Dual Rates

CY 2022 CCI Full Dual Rates

CalOptima received CY 2022 CCI full dual draft rates in September 2021 and final CY 2022 CCI full dual rates in January 2022. Highlights regarding these rates are as follows:

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- Final CY 2022 projected enrollment assumes the Public Health Emergency (PHE) will end in December 2021.
- Updated trend levels to reflect expected Mental Health Outpatient (MHOP) utilization and unit cost increases from CY 2019 base period to the CY 2022 contract period.
- The rates reflect a rebase that utilizes CY 2019 experience including health plan submitted RDTs and encounter data.
- The rebase also includes the following base-data adjustments:
    - Community Supports (formerly In Lieu of Services) – appropriately reported ILOS costs were removed from base data experience.
    - Global administrative adjustment for health plans who globally subcontract to another health plan.
    - Multipurpose Senior Services Program (MSSP) – data and cost for the MSSP Category of Service (COS) was removed from the base data due to MSSP services being carved out of managed care in CY 2022.
    - Category of aid (COA) adjustment – MSSP – only data reported in CY 2019 CCI RDTs was utilized to adjust the COA structure of the base data to match the COA structure of the CY 2022 rate period.
- Ground Emergency Medical Transportation (GEMT) adjustments
- Long – term care (LTC) program change, accounting for facility fee changes, was updated based on more recently published facility rate information.
- Program change adjustment quantifying the impact of adding skilled and trained Community Health Workers (CHWs) effective July 1, 2022.
- Non – medical transportation (NMT) amounts.
- Optional benefits restoration effective January 1, 2020.
- COVID-19 adjustment for mental health.
- Adjustments to the Whole Person Care (WPC) portion of Community Supports (ILOS) to utilize Eligible But Not Enrolled (EBNE) data rather than Cal MediConnect (CMC) data.
- These rates do not reflect any costs associated with pharmacy services for non – Cal MediConnect (CMC) COAs due to the pharmacy carve – out as of January 1, 2022.
- Rate add – ons for Enhanced Care Management (ECM) and Major Organ Transplant (MOT).
- MCO tax adjustments

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

Compared to CY 2021 rates, the final CY 2022rates are 0.3% or $1.31 PMPM higher for CCI Full Dual members. In aggregate, Staff projects the net fiscal impact for the period January 1, 2022, through June 30, 2022, will be slightly more favorable than the assumptions included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated rates for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima through the Rate Development Template (RDT) process and adjusted for trends and program changes. Execution of the

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contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Hunn *02/24/2022*

Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 10

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
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-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
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 the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

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
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Authorize and Direct Execution of Amendment(s) to CalOptima's Primary Medi-Cal Agreement with the California Department of Health Care Services Related to Rate Changes

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Medi-Cal Agreement between the California Department of Health Care Services and CalOptima related to rate changes.

Background

As a County Organized Health System (COHS), CalOptima contracts with the California Department of Health Care Services (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 the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the agreement through December 31, 2022. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to ensure that the Medi-Cal members DHCS assigns to CalOptima have access to covered health care services.

Discussion

DHCS has informed Managed Care Plans (MCPs), including CalOptima, that it will submit an agreement amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) rates, Coordinated Care Initiative (CCI) Non-Full Dual rates, Hyde (Abortion) rates, Behavioral Health Treatment (BHT) supplemental payments, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments.

Rate Changes

DHCS's proposed agreement amendment seeks to incorporate rates related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) rates, CCI Non-Full Dual rates, Hyde (Abortion) rates, BHT supplemental payments, MLTSS add–on rates, and Proposition 56 directed payments.

CY 2022 Rates

Base Classic Medi–Cal and ACA Optional Expansion Rates

Noteworthy items for the updated rates for January 2022 to December 2022 include, but are not limited to:

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- MCO tax add-on
- Program changes (as specified below)
- Risk adjustment updates
- Major Organ Transplant rate add-on
- Final Directed Payments/Pass-through payments
- Final projected enrollment

The base Medi–Cal Classic and ACA OE capitation rates for January 1, 2022 through December 31, 2022 were first sent to CalOptima as draft rates in July 2021, as updated draft rates in October 2021, and as final rates in January 2022. The rates reflect a rate rebase that now utilizes CY 2019 experience, including health plan submitted Rate Development Templates (RDTs) and encounter data. The rebase also includes the following:

- Base data adjustments for program changes such as:
  - Psychiatric Collaborative Care (PCC)
  - COVID-19 adjustments for mental health, testing, and treatment
  - Community Supports
  - Whole Person Care (WPC) related to Community Supports
  - Doula Benefit
  - Remote Patient Monitoring
  - Rapid Whole Genome Sequencing
  - Community Health Worker
  - Transitioning populations under CalAIM and for undocumented members aged 50 and over.

- Rate add -ons for the following:
  - MCO Tax
  - Proposition 56 Directed Payments
  - Hospital Quality Assurance Fee (HQAF) Payments
  - Major Organ Transplant (MOT)
  - Seniors and Persons with Disabilities (SPD) Community – Based Adult Services (CBAS)
  - Enhanced Care Management (ECM)

- Projected non-benefit costs for administrative and underwriting gain loads.
- Projected enrollment reflecting DHCS's current best estimate of enrollment for the CY 2022 rating period.
- Whole Child Model (WCM) rates utilizing a one-year base period, consistent with broader mainstream rates.
- CCI non – dual MLTSS capitation rates.
- Updated BHT supplemental payment rates using a CY 2018 and CY 2019 base data time period.

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CY 2022 ECM Add-on Per member per month (PMPM)

CalOptima received draft Enhanced Care Management (ECM) rates for January 2022 through December 2022 in May 2021 and final ECM rates in September 2021. Highlights regarding the ECM rate amounts include the following:

- Assumption changes impacting per enrollee per month (PEPM) costs
  - Service hours/caseloads: service hours and corresponding caseloads used in ECM base costs remain consistent.
  - Provider type salaries, trend and provider overhead: increase to base salaries and benefits for full time employees (FTE) providing ECM services.
  - Administrative load: full administrative load built into final ECM PMPM add-on rates.
- Assumption changes impacting ECM enrolled member counts
  - Whole Person Care (WPC) transitioning ECM members: assumed projected increase for transitioning WPC members remaining in ECM after six months.
  - Health Homes Program (HHP) transitioning ECM members: assumed projected increase for transitioning HHP members to remain in ECM after six months.
  - Identifying ECM eligible members for outreach and enrollment: number of members who would be ECM-eligible has increased based on updated analysis.
  - Modification of logic for health plans/counties with high WPC/HHP counts: updated rate methodology to acknowledge the resources required for transitioning WPC/HHP members into ECM.
- Other assumption changes
  - Outreach costs: outreach assumptions were revised to reflect the amount of hours spent on each outreach target.
  - Projected managed care enrollment update: the final ECM rates utilize updated 12-month projected enrollment counts that are based on actual enrollment observed through April 2021 with supplemental information through May 2021.

CY 2022 Community Supports Rates

CalOptima received draft Community Supports (ILOS) rates for January 2022 through December 2022 in August 2021 and final rates in January 2022.

Highlights regarding the Community Supports rate amounts include fully loaded PMPMs based on the following:

- Community Supports expense data provided in CalOptima's RDT submission.
- Whole Person Care (WPC) data.
- Community Supports within the CY 2022 capitation rates.

For further details regarding CalOptima's CY 2022 rates, please see "Attachment 2_Detailed Description of CY 2022 Rates."

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

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Fiscal Impact

Base Classic Medi-Cal and ACA Optional Expansion Rates:

Compared to CY 2021 rates, the final CY 2022 final rates are 11.6% or $22.48 PMPM higher for Medi-Cal Classic, 6.7% or $21.02 PMPM higher for Medi-Cal Expansion, and 18.6% or $269.41 PMPM higher for Medi-Cal WCM members. In aggregate, Staff projects the net fiscal impact for the period January 1, 2022, through June 30, 2022, will be more favorable than the assumptions included in the CalOptima Fiscal Year (FY) 2021-22 Operating Budget. Staff will include updated rates for the period of July 1, 2022, through December 31, 2022, in the CalOptima FY 2022-23 Operating Budget.

ECM and Community Support Services Rates:

The FY 2021-22 Operating Budget assumes that CalOptima will take financial risk for the mandatory ECM benefit and optional Community Support services effective January 1, 2022. Payments related to these new benefits and services were treated as budget neutral.

Rationale for Recommendation

DHCS develops capitation rates according to base data reported by CalOptima through the RDT process and adjusted for trends and program changes. Execution of the contract amendment will ensure revenues, expenses and cash payment are consistent with the approved budget to support CalOptima operations.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Appendix summary of amendments to Primary Agreements with DHCS
2. Detailed Description of CY 2022 Rates

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 11

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
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-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
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 the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

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
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

Detailed Description of CY 2022 Rates

The CY 2022 capitation rates may be amended later in year for the following reasons:

- Updates to capitation rates may occur when more information on the Public Health Emergency (PHE) end date is known.
- Capitation rates will be updated to separate the rates for beneficiaries with satisfactory immigration status versus unsatisfactory immigration status.

Program Changes, Efficiencies, and Other Adjustments:

a) All adjustments to the base data are listed below:

i. Psychiatric Collaborative Care (PCC)
ii. Prop 56 Community Based Adult Services (CBAS)
iii. Non-Medical Transportation (NMT)
iv. SB 523 Ambulance increases (GEMT)
v. Optional Benefits (Vision, Audiology, Podiatry, Incontinence creams and washes, and Speech Therapy)
vi. Long-Term Care (LTC)
vii. Hospice
viii. COVID Adjustments for Mental Health and Testing and Treatment
ix. Doula Benefit
x. Community Supports (ILOS) – approved ILOS reported in the CY 2019 RDT
xi. Whole Person Care (related to CalAIM ILOS)
xii. Remote Patient Monitoring
xiii. Continuous Glucose Monitoring DME Carve-out
xiv. Community Health Worker
xv. Populations transitioning from FFS to Managed Care (including those under CalAIM)
xvi. Population transition for members aged 50 and over to Full Scope Benefits regardless of immigration status (Undocumented 50+)
xvii. Rapid Whole Genome Sequencing
xviii. Dyadic Behavioral Health
xix. Population Acuity Adjustment
xx. Potentially Preventable Admissions efficiency adjustment (PPA)
xxi. Healthcare Common Procedure Coding System efficiency adjustment (HCPCS)
xxii. Emergency Department (ED) Adjustment for Low Acuity Non-Emergency (LANE) visit

Enrollment

This membership projection assumes the PHE will end in December 2021 and that DHCS will work through the backlog of eligibility redetermination within 12 months. These projections are based on actual enrollment with runout through July 2021 with supplemental information with runout through August 2021. This projected enrollment has been updated with best estimates for the CalAIM transitioning populations and undocumented 50+ groups.

Rate Add-Ons

Proposition 56
For the Physician, Developmental Screening, Trauma Screening, Family Planning, and Value-Based Purchasing (VBP) Prop 56 directed payments, the PMPM add-ons were adjusted for population acuity (consistent with the adjustment made for the broader rates) and populations transitioning from FFS to Managed Care.

The VBP Prop 56 directed payments were further adjusted for the transitioning population aged 50 and older with unsatisfactory immigration status that will transition to full-scope benefits during the CY 2022 rating period. VBP Prop 56 is scheduled to sunset as of July 1, 2022.

Hospital Quality Assurance Fee (HQAF) – the HQAF pass-through payment PMPM add-ons have been revised for final rates, due to enrollment projection updates.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Ratify Amendments to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Calendar Year (CY) 2022 Risk Mitigation Contract Amendment, CY 2021 COVID Vaccine Incentive Program Contract Amendment and 2022 Community Supports Contract Amendment

Contacts

Nancy Huang, Chief Financial Officer, (657) 235-6935
Carmen Dobry, Executive Director, Compliance, (657) 235-6997

Recommended Action

Ratify amendments to CalOptima's Primary Agreement between CalOptima and DHCS related to the Calendar Year (CY) 2022 Risk Mitigation Contract Amendment, CY 2021 COVID Vaccine Incentive Program Contract Amendment and CY 2022 Community Supports Contract Amendment

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 the DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 54, which extends the agreement through December 31, 2022. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

CY 2022 Risk Mitigation Contract Amendment

On October 20, 2021, DHCS notified managed care plans (MCPs), including CalOptima, that risk mitigation language will be added to MCP contracts for CY 2022 in order to comply with Title 42, Code of Federal Regulations (CFR), Section 438.6(b)(1) as required by the Centers for Medicare and Medicaid Services (CMS). As directed by CMS, DHCS is required to provide this fully executed contract amendment to CMS prior to 2022.

Title 42, CFR, Section 438.6(b)(1) took effect on December 14, 2020, it requires that applicable risk-sharing mechanisms be documented in the contract and rate certification documents for the rating period prior to the start of the rating period. These risk-sharing mechanisms must be developed in accordance with Title 42, CFR, Section 438.4, the rate development standards in Title 42, CFR Section 438.5, and generally accepted actuarial principles and practices. Under the terms of the final rule, risk-sharing mechanisms may not be added or modified after the start of the rating period.

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The CY 2022 Risk Mitigation Contract Amendment includes the following:

1. The risk-sharing arrangement shall be in effect for the complete Rating Periods covering dates of service January 1, 2022, through December 31, 2022, for those capitation increments, services, and populations associated with Enhanced Care Management (ECM), as determined by DHCS.
2. The risk-sharing arrangement may result in payment by the DHCS to CalOptima or by CalOptima to the DHCS in a form and manner specified by DHCS through All-Plan Letters (APLs) or other technical guidance.
3. The risk-sharing arrangement shall be symmetrical with respect to risk and profit and will be based on the results of an ECM Risk Corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance.
4. CalOptima shall provide and certify Allowable Medical Expense data necessary for the ECM Risk Corridor calculation in a form and manner specified by DHCS.
5. DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.
6. The ECM Risk Corridor, as outlined in this contract agreement amendment, will continue to apply in a form and manner specified by DHCS through APLs or other technical guidance for Rating Periods on or after January 1, 2023, if DHCS determines that the continuation of the risk-sharing arrangement is actuarially appropriate and necessary to account for the continuation of the ECM implementation.
7. Added definition of ECM to CalOptima's Primary Agreement with the DHCS.

CY 2021 COVID Vaccine Incentive Program

On December 1, 2021, DHCS notified MCPs, including CalOptima, that COVID vaccine incentive program language will be added to MCP contracts for the CY 2021 contract to comply with Title 42, CFR, Section 438.6(b)(2) as required by CMS. As directed by CMS, DHCS is required to provide this fully executed agreement amendment to CMS in early 2022.

The CY 2021 COVID Vaccine Incentive Program agreement amendment includes the following:

1. Reimburse Network Providers pursuant to the terms of each applicable Directed Payment Initiative and Pass-Through Payment in accordance with federal regulations in a form and manner specified by DHCS through APLs or other technical guidance.
2. Comply with the participation terms of member-direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) in a form and manner specified by DHCS through APLs or other technical guidance.

The agreement amendments do not contain any rate changes or otherwise set any rates. Staff has received finalized CY 2021 rates from the DHCS and received authority to execute that agreement amendment during the February 2021 meeting of the Board of Directors. Additionally, staff has received finalized CY 2022 rates from the DHCS and will subsequently

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request authority from the Board of Directors to authorize and direct the Chairman to execute such an amendment agreement.

On November 17, 2021, DHCS requested that CalOptima sign and return the CY 2022 Risk Mitigation Agreement Amendment as soon as possible, but no later than Tuesday, December 7, 2021, to ensure timely submission of the fully executed agreement amendment to CMS prior to 2022. In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on November 29, 2021, and returned the signed agreement amendment to DHCS.

Separately, on January 18, 2022, DHCS requested that CalOptima sign and return the CY 2021 COVID Vaccine Incentive Program Agreement Amendment as soon as possible, but no later than February 1, 2022, to ensure timely submission of the fully executed agreement amendment to CMS. In order to meet DHCS's deadline, CalOptima staff procured the Chair's signature on Tuesday, January 25, 2022, and returned the signed agreement amendment to DHCS.

As such, staff requests the CalOptima Board of Directors' ratification of the Board Chair's execution of the CY 2022 Risk Mitigation Agreement Amendment and the CY 2021 COVID Vaccine Incentive Program Agreement Amendment to CalOptima's Primary Agreement with the DHCS.

2022 Community Supports Contract Language

On January 14, 2022, DHCS provided the final CY 2022-B MCP Agreement Amendment to the MCPs that will incorporate Community Supports contract language into the MCP contracts. Staff received Board approval to execute an amendment to the Primary Agreement between DHCS and CalOptima for the Community Supports contract language during the October 7, 2021, meeting of the CalOptima Board of Directors.

The final agreement amendment contains notable language changes that were updated to explicitly reference certain requirements as stated in CMS's 1115 and 1915(b) waiver approvals for Community Supports. The notable language changes include more specific language on member protections and eligibility, limited changes to service definitions (e.g., related to state plan substitutes), requirements for documenting medical appropriateness, broad reporting requirements, and more flexible language on supplantation of other funding. Staff has included DHCS's additional detail regarding the notable changes to the agreement amendment as Attachment 5 in this COBAR. Due to the notable language changes outlined in this finalized agreement amendment, Staff requests that the CalOptima Board of Directors provide an updated authority to execute this contract amendment as a matter of ratification.

Fiscal Impact

CY 2022 Risk Mitigation Contract Amendment: The recommended action to ratify amended risk mitigation contract provisions for CY 2022 is projected to be budget neutral.

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CY 2021 COVID Vaccine Incentive Program: The recommended action to ratify amended COVID vaccine incentive program provisions for CY 2021 is projected to be budget neutral.

CY 2022 Community Supports Contract Amendment: The FY 2021-22 Operating Budget assumes CalOptima will take on financial risk for Community Supports services. Payments related to these services were treated as budget neutral. Staff will include updated operating expenses in the FY 2022-23 Operating Budget.

Rationale for Recommendation

CalOptima's execution of these agreement amendments to its Primary Agreement is necessary for the continued operation of CalOptima's Medi-Cal program.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Appendix summary of amendments to Primary Agreements with DHCS
2. 2022-A Risk Mitigation Amendment
3. 2021-C COVID Vaccination Incentive Program Amendment
4. 2022-B Final Draft for Community Supports Contract Language
5. Community Supports Program Document Changes

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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APPENDIX TO AGENDA ITEM 12

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
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-42 incorporated revised base rates for July 2017 to June 2018, directed payments language and mental health parity documentation requirements.	August 1, 2019
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 the new requirements of the 2018 Final Rule Amendment, Behavioral Health Treatment (BHT) and State Fiscal Year (SFY) 2018 – 19 capitation rates	June 7, 2018 August 1, 2019 August 6, 2020
A-46 incorporates full dual rates for Calendar Year (CY) 2018.	August 1, 2019
A-47 incorporates full dual rates for Calendar Year (CY) 2019.	October 1, 2020

A-48 incorporates new Bridge Period, Health Homes Program (HHP) and Whole Child Model (WCM) language and adds 2019 – 2020 capitation rates	June 7, 2018 October 1, 2020 February 4, 2021
A-49 extends the Primary Agreement with DHCS to December 31, 2021	November 5, 2020
A-50 incorporates full dual rates for Calendar Year (CY) 2020.	February 4, 2021
A-51 incorporates full dual rates for Calendar Year (CY) 2021.	February 4, 2021
A-52 incorporates Calendar Year (CY) 2021 base amendment contract language.	October 7, 2021
A-53 incorporates Calendar Year (CY) 2021 fall amendment contract language.	October 7, 2021
A-54 extends the Primary Agreement with DHCS to December 31, 2022.	October 7, 2021
A-55 incorporates full dual rates for Calendar Year (CY) 2022.	March 3, 2022
A-57 incorporates Calendar Year (CY) 2022 risk mitigation language.	March 3, 2022
A-58 incorporates the COVID Vaccination Incentive Program.	March 3, 2022

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
A-10 extends the Secondary Agreement with DHCS to December 31, 2021	November 5, 2020
A-12 extends the Secondary Agreement with DHCS to December 31, 2022.	October 7, 2021

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
A–05 extends the Agreement 16–93274 with DHCS to December 31, 2023.	June 3, 2021

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

IV. Exhibit B, BUDGET DETAIL AND PAYMENT PROVISIONS, is amended to add:

21. Enhanced Care Management (ECM) Risk Corridor

A. A risk-sharing arrangement shall be in effect for complete Rating Periods covering dates of services from January 1, 2022 through December 31, 2022, for those capitation increments, services and populations associated with ECM, as determined by DHCS.

1) The risk-sharing arrangement described in this Provision may result in payment by the State to Contractor or by Contractor to the State in a form and manner specified by DHCS through APLs or other technical guidance.

2) The risk-sharing arrangement shall be symmetrical with respect to risk and profit, and will be based on the results of an ECM Risk Corridor calculation performed in a form and manner specified by DHCS through APLs or other technical guidance, aggregated across applicable Medi-Cal Managed Care Contracts between Contractor and the State for those capitation increments, services, and populations, as determined by DHCS.

3) Contractor shall provide and certify Allowable Medical Expense data necessary for the ECM Risk Corridor calculation in a form and manner specified by DHCS. The data and any related substantiating documentation may be subject to review and adjustment at DHCS' discretion in a form and manner specified by DHCS through APLs or other technical guidance, and may be subject to audit by the State or its designee.

4) DHCS or its designee will initiate the ECM Risk Corridor calculation for a given Rating Period no sooner than 12 months after the end of the applicable Rating Period.

B. If DHCS determines that the continuation of the risk-sharing arrangement is actuarially appropriate and necessary to account for the impacts of the ECM implementation, the ECM Risk Corridor, as described in Paragraph A of this Provision, shall continue to apply in a form and manner specified by DHCS through APLs or other technical guidance for Rating Periods starting on or after January 1, 2023.

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

> **Enhanced Care Management (ECM) means a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Members who meet ECM Populations of Focus eligibility criteria through a systemic coordination of services and comprehensive case management that is community-based, interdisciplinary, high-touch, and person-centered.**

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

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

Budget Detail and Payment Provisions

1. Budget Contingency Clause
2. Amounts Payable
3. Contractor Risk in Providing Services
4. Capitation Rates
5. Capitation Payment Rates Constitute Payment in Full
6. Determination of Capitation Payment Rates
7. Redetermination of Capitation Payment Rates - Obligation Changes
8. Reinsurance
9. Catastrophic Coverage Limitation
10. Financial Performance Guarantee
11. Recovery of Amounts Paid to Contractor
12. Medical Loss Ratio (MLR)
13. Adult Expansion Risk Corridor
14. Supplemental Payments
15. Additional Payments
16. Special Contract Provisions Related to ~~Directed~~ Payment ~~Initiatives and Pass-Through Payment Programs~~

~~17. Special Contract Provisions Related to Incentive Arrangements~~

~~18~~**17**. Medicare Coordination

~~19~~**18**. Covid-19 Risk Corridor

~~20~~**19**. State Programs Receiving Federal Financial Participation

16. Special Contract Provisions Related to ~~Directed~~ Payment ~~Initiatives and Pass-Through Payment Programs~~

A. Contractor must ~~comply, and require its Subcontractors to comply, with the~~ **reimburse Network Providers pursuant to the** terms of each applicable Directed Payment Initiative ~~established~~ in accordance with 42 CFR **section** 438.6(c), in a form and manner specified by DHCS through ~~All Plan Letters~~ **APLs** or other technical guidance. For applicable Rating Periods, DHCS shall make the terms of each Directed Payment Initiative available on the ~~DHCS website at~~ ~~www.dhcs.ca.gov~~ **DHCS website**.

B. Contractor must ~~comply, and require its Subcontractors to comply, with~~ **reimburse Network Providers pursuant to** the terms of each applicable Pass-Through Payment established pursuant to 42 CFR **section** 438.6(d)**,** in accordance with the CMS**-**approved rate certification, and in a form and manner specified by DHCS through ~~All Plan Letter~~ **APLs** or other technical guidance.

~~17. Special Contract Provisions Related to Incentive Arrangements~~

C. Contractor must comply with the terms of any Incentive Arrangements approved by CMS under 42 CFR **section** 438.6(b)(2), in a form and manner specified by DHCS through ~~All Plan Letters~~ **APLs** or other technical guidance. For applicable Rating Periods, ~~commencing with the Rating Period starting July 1, 2019,~~ DHCS ~~shall~~ **will** make the terms of each approved Incentive Arrangement available on the ~~DHCS website at www.dhcs.ca.gov~~ **DHCS website**.

D. To participate in Member direct incentive programs approved in the Public Assistance Cost Allocation Plan (PACAP) by the U.S. Department of Health and Human Services Division of Cost Allocation Services, with CMS concurrence, Contractor must comply with the terms of those programs as set forth in the PACAP in a form and manner specified by DHCS through APLs or other technical guidance. For Rating Periods in which Member direct incentive programs are effective, commencing with the Rating Period starting January 1, 2021, DHCS shall make the terms of each approved Member direct incentive program available on the DHCS website.

1~~8~~7. Medicare Coordination

1~~9~~8. Covid-19 Risk Corridor

~~20~~19. State Programs Receiving Federal Financial Participation

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

18. Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.

1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered a Community Supports, is currently receiving a Community Supports, or has received a Community Supports in the past.

2) Contractor may not require a Member to utilize a Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered Services on the same terms as would apply if a Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS' guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each

Community Supports, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

1) Contractor is not permitted to extend a Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.

2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.

D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.

F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.

G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from

offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.

I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a D-SNP, Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

19. DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing Transition Navigation Services;

2) Housing Deposits;

3) Housing Tenancy and Sustaining Services;

4) Short-Term Post-Hospitalization Housing;

5) Recuperative Care (Medical Respite);

6) Respite Services;

7) Day Habilitation Programs;

8) Nursing Facility Transition/Diversion to Assisted Living Facilities;

9) Community Transition Services/Nursing Facility Transition to a Home;

10) Personal Care and Homemaker Services;

11) Environmental Accessibility Adaptations;

12) Medically Tailored Meals/Medically Supportive Food;

13) Sobering Centers; and

14) Asthma Remediation.

B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an alternate approach requested by Contractor.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing Community Supports, Contractor must notify Members affected by the discontinuation of the Community Supports of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition

into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

20. Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.

B. Contractor must enter into Subcontractor Agreements with Community Supports Providers for the delivery of elected Community Supports elected by Contactor.

C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member information including eligibility, Community Supports authorization status,

Member authorization for data sharing to the extent required by law, and other relevant demographic and administrative information; and

2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.

D. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

21. Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure its contracted Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

22. Community Supports MOC

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.

B. In developing and executing Subcontractor Agreements with Community Supports Providers, Contractor must incorporate

all requirements and policies and procedures described in its Community Supports MOC, in addition to all applicable APLs.

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement boilerplates.

23. Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable APLs.

B. Contractor must develop policies and procedures for Community Supports, an submit its policies and procedures to DHCS for review and approval prior to its implementation. Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will accept requests for Community Supports from Providers, other community-based entities, and Member or Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods

for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

E. Transition of WPC and HHP to Community Supports

1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.

2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers, regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:

a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;

b) There is a justified quality of care concern with the Community Supports Provider;

c) Contractor and the Community Supports Provider are unable to agree on contracted rates;

d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement;

e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement;

f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

g) The Community Supports Provider without a State-level pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

24. Authorizing Members for Community Supports and Communication of Authorization Status

A. Contractor must develop policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that will be undertaken if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.

D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.

E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.

1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.

2) Contractor must evaluate and document whether a

service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not automatically mean that providing other Community Supports to the same Member, the same Community Supports to another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.

F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.

G. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requesting entity and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.

I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

25. Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider

referrals will occur. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.

1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider are known, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving the Community Support is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed, to support the Member and maximize the benefits of Community Supports, in accordance with all applicable APLs;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if Contractor intends to do so.

26. Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State, and if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the following as part of the referral process to the Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

27. Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract, and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Subcontractor Agreements with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation, Contractor must ensure the following:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.

3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements as described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

28. Delegation of Community Supports Administration to

Subcontractors

A. Contractor may enter into Subcontractor Agreements with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

2) Contractor is responsible for developing and maintaining DHCS-approved policies and procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

3) Contractor must evaluate the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

4) Contractor must ensure the Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must report to DHCS the names of all Subcontractors by type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Subcontractor Reports; and

6) Contractor must make all Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must ensure that the Subcontractor Agreement mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor.

C. Contractor may collaborate with its Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and ensure a streamlined, seamless experience for Community Supports Providers and Members.

29. Payment of Community Support Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.

2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

30. DHCS Oversight of Community Supports

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of a Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

31. Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with DHCS policies and guidance.

Changes to Community Support Program Documents to Reflect Final Waiver Approval Terms

1/12/22

Overview of CMS Approvals

- CMS approved all 14 Community Supports:
  - Recuperative Care and Short-Term Post Hospitalization Housing are approved under 1115 waiver authority
  - All 12 of the other Community Supports are approved under the 1915(b) waiver authority
- Both waiver documents outline specific federal requirements for these services. All requirements in the 1915(b) waiver terms also apply to the two services in the 1115 waiver.
- These requirements largely align with existing contract requirements, processes, and reporting already planned in California. However, CMS required California to update contract documents to explicitly reference certain items in the waiver terms.

Overview of Changes

- California has updated the following documents to match final waiver terms and conditions, as required by CMS:
  - State/MCP Contract (2022-B Amendment)
  - 21-017 Community Supports (ILOS) All Plan Letter
  - DHCS Community Supports Policy Guide
- Changes include:
  - More specific language on beneficiary protections and eligibility
  - Limited changes to service definitions (e.g. related to state plan substitutes)
  - Requirement for documenting medical appropriateness
  - Broad reporting requirements
  - More flexible language on supplantation of other funding

Beneficiary Protections

1915(b) STC Requirements

- Each ILOS must not be used to reduce services to beneficiaries or jeopardize Medicaid beneficiaries' access to Medicaid state plan covered services.
- Medicaid beneficiaries always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if an ILOS were not an option in accordance with regulatory requirements
- Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that the beneficiary has been offered an ILOS, is currently receiving an ILOS, or has received an ILOS in the past.
- Managed care plans are prohibited from requiring a beneficiary to utilize an ILOS.

2022-B Amendments, pg. 92

B. In accordance with 42 CFR section 438.3(e)(2), ~~and~~ all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.

1. Contractor must ensure ~~the underlying~~ medically appropriate State Plan services are available to the Member ~~if medically appropriate for the Member, or if the Member declines the Community supports~~ regardless of whether the Member has been offered a Community Support, is currently receiving a Community Support, or has received a Community Support in the past.
2. Contractor may not require a member to utilize a Community Support. Members always retain their right to receive the Medicaid state plan covered service on the same terms as would apply if a Community Support was not an option in accordance with regulatory requirements.
3. Contractor must not use Community Supports to reduce services to Members or jeopardize Members' access to State Plan services.

Beneficiary Protections, Cont.

1915(b) STC Requirements

Medicaid beneficiaries always retain the right to file appeals and/or grievances if they request one or more ILOS offered by their Medicaid managed care plan, but were not authorized to receive the requested ILOS because of a determination that it was not medically appropriate or cost effective.

2022-B Amendments, pg. 102

24. Authorizing Members for Community Supports and Communication of Authorization Status

H. Member always retains the right to file appeals and/or grievances if they request one or more Community offered by the Contractor, but were not authorized to receive the requested Community Support because of a determination that it was not medically appropriate or cost effective.

** Parallel language on grievances also added to the Policy Guide pg.64*

Eligibility and Service Definitions

1915(b) STC Requirements

- Managed care plans have the discretion to adopt a more narrowly defined eligible population than the state has outlined (in its service definitions).
- Managed care plans must receive State approval and provide public notice of any such limitations on each ILOS, including specifying such limitations in the enrollee handbook.
- Managed care plans are not allowed to extend any ILOS to individuals beyond those for whom the state has determined the ILOS will be cost effective and medically appropriate.
- Managed care plans must ensure all eligibility standards are designed and applied on a non-discriminatory manner.

2022-B Amendments, pg. 93

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each Community Supports, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

1) Contractor is not permitted to extend a Community Support to individuals beyond those for whom DHCS has determined the Community Support will be cost- effective and medically appropriate, as indicated in DHCS guidance on eligible populations.
2) Contractor must provide public notice of any limitations on Community Supports when they request an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor website, in addition to receiving DHCS' written approval.

Eligibility and Service Definitions, Cont.

Although not explicit in STCs, CMS also asked California to update the service definition for Meals/Medically Tailored Meals/Medically Supportive Foods to avoid prohibitions on funding for "room and board" outside of the 1115 waiver.

Policy Guide, Meals/Medically Tailored Meals/Medically Supportive Foods, p. 52

Up to ~~three~~ two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.

Eligibility and Service Definitions, Cont.

1915(b) STC Requirements

Well defined, clinically oriented definitions developed by the state for the target population(s) for which each ILOS has been determined by the state to be a medically appropriate and cost effective substitute. These state definitions, included within the managed care plan contracts, must outline the population(s) for whom each ILOS is clearly likely to improve overall health outcomes, reduce cost, and reduce or prevent utilization of other state plan services (e.g., acute care).

Policy Guide – Community Supports to State Plan Services Crosswalk, pg. 59-63

- A chart that summarizes potential state plan services or settings that each of California's "pre-approved" Community Supports may substitute for has been added, replacing language in each service definition on services to avoided

Medical Appropriateness Documentation

1915(b) STC Requirements

A documented process to authorize an ILOS for beneficiaries for whom there is an assessed risk of incurring other Medicaid state plan services, such as inpatient hospitalizations, skilled nursing facility stay, or emergency department visits. This process must document that a provider (at the plan or network level) using their professional judgment has determined it to be medically appropriate for the specific beneficiary as provision of the ILOS is likely to reduce or prevent the need for acute care or other Medicaid services. This documentation could be included in a care plan developed for the beneficiary. In addition to this clinical documentation requirement, the state may also impose additional provider qualifications or other limitations and protocols and these must be documented within the managed care plan contracts.

2022-B Amendments, pg. 101

C. Contractor must validate ~~and document~~ Member eligibility for Community Supports using a consistent methodology and authorize Community Supports for Members for whom the Community Supports are determined to be a medically appropriate and cost-effective alternative to Covered Services and settings under the California Medicaid State Plan.

1) Contractor must document its process for determining documentation to ensure appropriate clinical support for the medical appropriateness of Community Supports. This process must detail that provision of the Community Support, recommended by a provider at the plan or network level using their professional judgement, is likely to reduce or prevent the need for acute care or other Medicaid services, including but not limited to inpatient hospitalizations, skilled nursing facility stays, or emergency department visits. Therefore, the Community Support is medically appropriate for that Member.

2022-B Amendments, pg. 102

E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.

2) Contractor must evaluate and document whether a service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member.

* Policy Guide p. 70 – 71 includes more examples of how existing processes can be used to meet this requirement.

Data and Reporting

1915(b) STC Requirements

Managed care plans must timely submit any related data requested by the state or CMS, including, but not limited to:

- Data to evaluate the utilization and effectiveness of an ILOS.
- Data necessary to monitor health outcomes and quality metrics at the local and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities.
- Data necessary to monitor appeals and grievances for beneficiaries associated with an ILOS.

2022-B Amendments, pg. 102

24. Authorizing Members for Community Supports and Communication of Authorization Status

I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor appeals and grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

2022-B Amendments, pg. 109

30. DHCS Oversight of Community Supports

d) Encounter data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of a Community Support.
2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.
3) Data necessary to monitor Member appeals and grievances associated with Community Supports.

Non-Supplantation of Other Funding

1115 STC Requirements

Community Supports shall supplement and not supplant services received by the MediCal enrollee through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Policy Guide – Service Definitions, pg. 6-58

- Each service description/overview has been updated with:
  Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. ~~Individuals may not be receiving duplicative support from other State, local, or federally funded programs, which should always be considered first, before using Medi-Cal funding.~~

Note: California sought to ensure updated language in STCs allows for appropriate application of the federal guidance related to the provision of free care:

https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

13. Authorize an Amendment to Contract MS-21-22-41 with the California Department of Aging to Expand Member Slots in the Multipurpose Senior Services Program

Contacts

Richard Pitts, Chief Medical Officer, (714) 347-5750
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Adopt Board Resolution No. 22-0303-03, authorizing and directing the Chairman of the Board of Directors to execute the Fiscal Year (FY) 2021–22 contract amendment with the California Department of Aging (CDA) to expand member slots in the Multipurpose Senior Services Program (MSSP)

Background

The MSSP is a home and community-based services program operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care services as a cost-effective alternative to institutionalization of frail, elderly adults.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the CDA. The CDA contracts with local government entities and private non-profit organizations for local administration of MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past 20 years for up to a maximum of 455 members at any given point in time. Currently, CalOptima serves the maximum 455 members. Because of the 2008-09 recession budget cuts, MSSP suffered the loss of 2,497 client slots statewide. As a result of restoring MSSP to pre-recession service levels, the CDA has allocated 113 new member slots, increasing the total members to be served by CalOptima to 568, effective January 1, 2022.

Discussion

The proposed contract amendment increases MSSP reimbursement from $2,437,071 to $2,739,640 for the remainder of Fiscal Year (FY) 2021–22. The scope of work and other contract obligations are consistent with the existing contract. The increased reimbursement would be utilized to hire five additional MSSP staff to provide care management and administrative support for the 113 additional member slots allocated by CDA. The increase in member slots is needed to address the ongoing wait list and reduce the number of days that CalOptima members wait for program enrollment. The recommended action will help support the ongoing community needs for MSSP services.

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Fiscal Impact

The fiscal impact of the MSSP contract amendment increases the maximum amount to $2,739,640, or a net increase of $302,569 for the period of January 1, 2022, through June 30, 2022. These changes have been included in the proposed, revised FY 2021-22 MSSP Operating Budget pending Board approval under a separate action.

Rationale for Recommendation

Executing the FY 2021–22 contract amendment with the CDA for the MSSP program to expand member slots and staffing will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Board Resolution No. 22-0303-03, Execute Contract No. MS-21-22-41, Amendment A1 with the State of California Department of Aging for the Multipurpose Senior Services Program
2. CDA MSSP Contract MS-21-22-41, Amendment A1 Signature Page

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0303-03

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

EXECUTE CONTRACT AMENDMENT NO. MS-21-22-41-A1
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to AMEND contract for the assignment of up to 568 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-21-22-41-A1; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community-based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-21-22-41-A1 with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 3rd day of March 2022.

AYES: _____

NOES: _____

ABSENT:_____

ABSTAIN: _____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES

SCO ID: 4260-MS212241-A1

STANDARD AGREEMENT - AMENDMENT

STD 213A (Rev. 4/2020)

☒ **CHECK HERE IF ADDITIONAL PAGES ARE ATTACHED 1 PAGE**

AGREEMENT NUMBER	AMENDMENT NUMBER	Purchasing Authority Number
MS-2122-41	1	

1. This Agreement is entered into between the Contracting Agency and the Contractor named below:

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTOR NAME
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

2. The term of this Agreement is:

START DATE
07/01/2021

THROUGH END DATE
06/30/2022

3. The maximum amount of this Agreement after this Amendment is:
$ 2,739,640 Two million seven hundred thirty-nine thousand six hundred forty and 00/100 dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

A. This amendment increases the total amount of the Agreement by $ 302,569. The new total of the Agreement shall not exceed $2,739,640.

B. Exhibit A, Attachment 1, General Information, Item 1, last sentence, is hereby amended to read: "The number of client months under this Agreement is 6,138."

C. The attached Budget Display Exhibit B, Attachment 1 – Budget Display, identified as Amendment 1, replaces the Original Exhibit B, Attachment 1 – Budget Display (1 page). The Budget, Amendment 1, is hereby incorporated by reference and replaces the original referenced Budget.

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
505 City Parkway West	Orange	CA	92868

PRINTED NAME OF PERSON SIGNING	TITLE

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME
California Department of Aging

CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
2880 Gateway Oaks Drive, Suite 200	Sacramento	CA	95833

PRINTED NAME OF PERSON SIGNING	TITLE
Nate Gillen	Chief, Business Management Bureau

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	SCM, Volume 1, 4.04, A., (4)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

14. Authorize Extending Contract with Health Management Associates for Consulting Services to Assist with Preparation and Remediation for the Department of Health Care Services (DHCS) Routine Medical Audit Scheduled for January 2022 and Authorize Expenditures from Existing Reserves for such Services.

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Michael Hunn, Interim Chief Executive Officer, (657) 900-1481

Recommended Action(s)

1. Authorize contract extension from June 30, 2022, to December 31, 2022.
2. Authorize unbudgeted expenditures in an amount up to $75,000 from existing reserves to fund this contract through December 31, 2022.

Background

The Department of Health Care Services (DHCS) routinely conducts audits of CalOptima's Medi-Cal program. The audit can consist of, but is not limited to, an evaluation of CalOptima's compliance with its DHCS contracts and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

The medical survey was comprised of:

- Reviewing CalOptima's policies for providing services;
- Reviewing the procedures used to implement CalOptima's policies;
- Verifying and implementing the effectiveness of the policies through file reviews; and
- Interviewing CalOptima's administrators, staff, and delegated entities.

CalOptima received the approval of the CalOptima Board of Directors to execute a contract with HMA for consulting services in preparation for the DHCS medical audit, and to assist with addressing subsequent findings and corrective actions, as necessary.

DHCS will provide a draft audit report in Spring 2022. The draft audit report includes the potential findings and recommendations discovered during the audit period. CalOptima has fifteen (15) calendar days to review the draft audit report and provide a rebuttal, including additional supporting documentation, if necessary. DHCS will review the rebuttal and submit a final audit report to CalOptima. CalOptima will have thirty (30) calendar days to review the final audit report and provide a detailed Corrective Action Plan (CAP) for each recommendation noted within the final report.

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Discussion

In preparation for the upcoming DHCS medical audit, the Board Ad Hoc Committee comprised of Chair Andrew Do, Vice Chair Clayton Corwin, Director Scott Schoeffel and Director Clayton Chau, M.D selected HMA as a vendor partner to serve as an adjunct to CalOptima's Compliance Department and directed staff to negotiate a contract with HMA to assist with the DHCS annual medical audit.

On October 7, 2021, the CalOptima Board of Directors approved unbudgeted expenditures in an amount up to $250,000 from existing reserves to fund a contract with HMA through June 30, 2022. HMA has effectively assisted CalOptima's efforts to ensure audit readiness; however, CalOptima requires HMA's ongoing assistance to ensure appropriate remedial efforts and effective corrective action plans are implemented.

As such, staff requests the CalOptima Board of Directors provide an updated authority to execute HMA's contract extension and fund additional expenditures.

Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $75,000 from existing reserves will fund the extended contract through December 31, 2022.

Rationale for Recommendation

The recommended action is unbudgeted. An additional allocation of up to $75,000 from existing reserves will fund this action through December 31, 2022.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by the Recommended Board Action
2. Previous Board Action dated October 7, 2021: Authorize Contract with HMA for Consulting Services to Assist for DHCS Routine Medical Audit and Authorize Expenditures from Reserves to Fund

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Associates	120 North Washington Square, Suite 705	Lansing	MI	48933

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing Contract with Health Management Associates for Consulting Services to Assist in Preparation for the Department of Health Care Services Routine Medical Audit Scheduled for January 2022, and Authorize Expenditures from Existing Reserves for Such Services

Contacts

Carmen Dobry, Executive Director, Compliance, (657) 235-6997
Richard Sanchez, Chief Executive Officer, (657) 900-1481

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a contract with HMA for consulting services to prepare for the Department of Health Care Services (DHCS) medical audit, and assist with addressing subsequent findings and corrective actions, as necessary; and
2. Authorize unbudgeted expenditures in an amount up to $250,000 from existing reserves to fund this contract through June 30, 2022.

Background

The Department of Health Care Services (DHCS) routinely conducts audits of CalOptima's Medi-Cal program and plans to conduct a routine medical audit in January 2022. The audit can consist of, but is not limited to, an evaluation of CalOptima's compliance with its DHCS contracts and regulations in the areas of utilization management, case management and coordination of care, availability and accessibility, member rights, quality management, and administrative and organizational capacity.

The medical survey is comprised of the following activities:

- Reviewing CalOptima's policies for providing services,
- Reviewing the procedures used to implement CalOptima's policies,
- Verifying the implementation and effectiveness of the policies through file reviews,
- Interviewing CalOptima's administrators, staff, and delegated entities, and
- Conducting Facility (Provider) Site Visits and Medical Record Reviews.

Around late January 2022, CalOptima will be formally engaged for the annual DHCS Medical Survey covering the lookback period of February 1, 2020 – current. It is important to note the lookback period is longer than the normal annual review period due to the delay that COVID has caused. The scope of the DHCS Medical Survey may include the following categories:

Audit Scope
Utilization Management
Case Management and Coordination of Care • Behavioral Health Treatment

Access and Availability • Claims
Member Rights • Grievances • Appeals
Quality Improvement • Potential Quality Issues (PQI)
Administrative and Organizational Capacity • FWA • HIPAA
State Supported Service

When DHCS formally engages CalOptima, the following actions occur:

- Reviewing the pre-audit information, received by DHCS, and developing a workplan following the referencing system, and submitting the documentation responses and attachments to DHCS within thirty (30) days of receipt.
    - The pre-audit information request includes, but is not limited to, the following for all requested categories:
        - Policies and Procedures
        - Program Descriptions/Program Evaluations
        - Universe requests
        - Organizational Charts
        - Questionnaires
        - Delegated Activities
- DHCS provides Verification Studies (file reviews) to CalOptima. CalOptima has approximately two (2) weeks to submit the numerous verification studies back to DHCS.
    - The verification studies include the review and development of multiple case files across multiple disciplines within CalOptima.
- DHCS begins their designated onsite portion of the audit (Due to COVID this portion will be via webinar). This portion is scheduled for a **two (2) week period** in which the following activities occur:
    - Scheduled interviews
    - Ad-hoc interviews
    - File review
    - Additional onsite (ad-hoc) document requests
- At the close of the audit, DHCS will provide a draft audit report. The draft audit report includes the potential findings and recommendations discovered during the audit period. CalOptima has fifteen calendar (15) days to review the draft audit report and provide a rebuttal, including additional supporting documentation.

- DHCS will review the rebuttal and submit a final audit report to CalOptima. At that time, CalOptima will have thirty calendar (30) days to review the final audit report and provide a detailed Corrective Action Plan (CAP) for each recommendation noted within the final report.

Discussion

In preparation for the upcoming DHCS medical audit, the Board Ad Hoc Committee comprised of Chair Andrew Do, Vice Chair Clayton Corwin, Director Scott Schoeffel and Director Clayton Chau, M.D selected HMA as a vendor partner to serve as an adjunct to CalOptima's Compliance Department and directed staff to negotiate a contract with HMA to assist with the Department of Health Care Services annual medical audit.

Project Description

The engagement will include:

- Pre-audit preparation – HMA shall be available in-person and remotely via videoconference, email, and/or telephone to provide guidance and to assist in reviewing reports, data sets, and other documents requested by the regulatory entity;
- Onsite support during audit readiness activities- HMA shall be available in-person to conduct audit readiness activities including but not limited to reviewing data sets, reports, clinical-focused file selections and other documents as deemed necessary in preparation for the regulatory audit;
- Onsite support during Audit (as-needed) - HMA shall be available to support the organization and assist in preparing, compiling, and reviewing requested documents during the onsite visit;
- Areas of focus for the audit readiness activities and regulatory audit may include at least the following, but may be expanded upon pursuant to agreement between CalOptima and HMA:
    - Claims;
    - Language Assistance Program;
    - Access to Emergency Room and Payment;
    - Member Rights;
    - Access and Availability;
    - Grievance and Appeals;
    - Utilization Management;
    - Post-Stabilization Authorizations;
    - Provider Training; and
    - Quality Improvement

Post- audit Corrective Actions (as-needed) - HMA shall be available to:

- Assist CalOptima in responding to regulatory audit findings, as needed;
- Assist CalOptima in developing any remedial work plan(s), as needed;
- Assist CalOptima in identifying resources necessary from Plan or delegate(s) to assure task completion; and

- Assist CalOptima in developing or improving a program to oversight first tier, downstream and related entities related to audit findings or other issues or concerns identified by CalOptima or the regulatory entity.

Project Milestones (Proposed)

- Audit Readiness Activities - October 2021 to TBD
- Assistance in preparing pre-audit documents - November 2021 to TBD
- Assistance in preparing for the audit - December 2021/January 2022 to TBD
- Post visit corrective actions – February 2022 to TBD

Fiscal Impact

The recommended action is unbudgeted. An allocation of up to $250,000 from existing reserves will fund this action through June 30, 2022.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *09/30/2021*
Authorized Signature **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Health Management Associates	120 North Washington Square, Suite 705, Lansing	Lansing	MI	48933

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

15. Approve Modifications to CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services

Contacts

Richard Pitts, Chief Medical Officer, (714) 347-5750
Marie Jeannis, RN, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Approve Modifications to CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services in accordance with regulatory requirements.

Background

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.

Discussion

Policy GG.1665 Telehealth and Other Technology-Enabled Services describes the requirements for coverage and reimbursement of telehealth covered services. Policy GG.1665 was revised to add the following:

1. Telehealth services can be used as an alternative means of access in accordance with CalOptima Policy GG.1600: Access and Availability Standards.
2. Telehealth services should be encouraged during a public health emergency when social distancing is required.
3. Providers will use secure video conferencing and evidence-based digital tools for telehealth services.

The policy changes provide additional clarity, aligns policy with current operations, and allows CalOptima and its providers to comply with applicable state and federal program requirements.

Fiscal Impact

The recommended action to approve changes to GG.1665 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the Board of Directors approve and adopt Policy GG.1665: Telehealth and Other Technology-Enabled Services. The updated policy and procedure will supersede prior versions.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Policy GG.1665 Telehealth and Other Technology-Enabled Services (Redlined and Clean)
2. Summary of Changes to Policy GG.1665: Telehealth and Other Technology-Enabled Services

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Policy:	GG.1665
Title:	**Telehealth and Other Technology-Enabled Services**
Department:	Medical Management
Section:	Population Health Management
Interim CEO Approval:	*/s/*
Effective Date:	03/01/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 2022030 - BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. CalOptima and Health Networks may use Telehealth Providers when they are unable to meet time or distance standards and to increase the network capacity when submitting Alternative Access Standard (AAS) requests, in accordance with CalOptima Policy GG.1600: Access and Availability Standards.

~~C.~~D. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

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5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

~~D.~~E. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

~~E.~~F. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

~~F.~~G. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

~~G.~~H. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

~~H.~~I. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

~~I.~~J. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) ~~20-003~~21-006: Network Certification Requirements, as well as any applicable DHCS guidance.

~~J.~~K. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

~~K.~~L. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

M. During a public health emergency limiting in-person contact, CalOptima and Health Network providers shall implement telephonic and/or video visits in place of face-to-face interactions according to Member need and preference and to mitigate disease transmission.

N. CalOptima or a Health Network shall ensure Qualified Providers utilize secure video conferencing and evidence-based digital tools as a supplement to in-person visits, as appropriate, and in compliance with regulatory guidance.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

For 2022 0303 BOD Review Only

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D. of this Policy.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The ~~medical record~~Medical Record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

For 20220303 BOD Review Only

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

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b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

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ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

   a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

   b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: ~~Appeals~~Appeal Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and 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~~for which CalOptima is Financially Responsible.

IV. ATTACHMENT(S)

Not Applicable

~~A. Addendum: COVID-19 Emergency Provisions~~

V. REFERENCE(S)

For 20220306 BOD Review Only

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group
C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
~~B.~~D. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
E. CalOptima Policy GG.1505: Transportation: Emergency, Non-emergency and Non-medical
~~C.~~F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~D.~~G. CalOptima Policy GG.1510: ~~Appeals~~Appeal Process
H. CalOptima Policy GG.1600: Access and Availability Standards
~~E.~~I. CalOptima Policy GG.1603: Medical Records Maintenance
~~F.I. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners~~
~~G.~~J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~H.I. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group~~
~~I. 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~~
~~J.~~L. CalOptima Policy HH.1102: Member Grievance
~~K.~~M. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
N. California Business and Professions Code §2290.5(a)(6)
~~L.~~O. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
~~M.~~P. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
~~N.~~Q. Department of Health Care Services All Plan Letter (APL) ~~20-003~~21-006: Network Certification Requirements
~~O.~~R. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
~~P.~~S. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal
Revised	TBD	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

For 20220303 BOD Review Only

IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
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~~Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter ~~18~~(APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article ~~3.9~~5.51, beginning with section ~~14127), effective January 1, 2020 for HHP Members with eligible physical chronic conditions and substance use disorders,~~14184.100), 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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 2022-03 BOD Review Only

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health ~~Centers~~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.~~An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
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.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details

For 2022

Term	Definition
Medically Necessary or Medical Necessity	~~Necessary services~~ Reasonable and necessary 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, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment ~~of disease, illness, or injury. Services must be provided~~(EPSDT) standard of Medical Necessity set forth in ~~a way that provides all protections to the Enrollee provided~~Section 1396d(r)(5) of Title 42 of the United States Code, as required by ~~Medicare and Medi-Cal. Per Medicare,~~W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services ~~must be reasonable and necessary~~ for ~~the diagnosis or treatment of illness~~Members under 21 years of age include Covered Services necessary to achieve or ~~injury~~maintain age-appropriate growth and development, attain, regain or ~~to~~ maintain functional capacity, or improve, support or maintain 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~~Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the ~~diagnosis or treatment of disease, illness, or injury under WIC Section 14059.5~~individual needs of the child.
Medical Record	~~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.~~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.
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.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.

For 20220203 BOD Review Only

Term	Definition
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
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.~~An entity defined in Title 22 CCR Section 51115.5.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 20220303 BOD Review Only

Policy:	GG.1665
Title:	**Telehealth and Other Technology-Enabled Services**
Department:	Medical Management
Section:	Population Health Management
Interim CEO Approval:	*/s/*
Effective Date:	03/01/2020
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 2022030-BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. CalOptima and Health Networks may use Telehealth Providers when they are unable to meet time or distance standards and to increase the network capacity when submitting Alternative Access Standard (AAS) requests, in accordance with CalOptima Policy GG.1600: Access and Availability Standards.

D. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

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5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

E. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

F. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

G. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

H. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

I. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

J. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 21-006: Network Certification Requirements, as well as any applicable DHCS guidance.

K. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

L. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

M. During a public health emergency limiting in-person contact, CalOptima and Health Network providers shall implement telephonic and/or video visits in place of face-to-face interactions according to Member need and preference and to mitigate disease transmission.

N. CalOptima or a Health Network shall ensure Qualified Providers utilize secure video conferencing and evidence-based digital tools as a supplement to in-person visits, as appropriate, and in compliance with regulatory guidance.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

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2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D. of this Policy.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

   a. The Qualified Provider meets the following licensure requirements:

      i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

      ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

   a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

   b. The Member has provided verbal or written consent in accordance with this Policy;

   c. The Medical Record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

   d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

   e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

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f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

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b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

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ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

   a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

   b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeal Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

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 FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
D. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
E. CalOptima Policy GG.1505: Transportation: Emergency, Non-emergency and Non-medical
F. CalOptima Policy GG.1508: Authorization and Processing of Referrals
G. CalOptima Policy GG.1510: Appeal Process
H. CalOptima Policy GG.1600: Access and Availability Standards
I. CalOptima Policy GG.1603: Medical Records Maintenance
J. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
K. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
L. CalOptima Policy HH.1102: Member Grievance
M. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
N. California Business and Professions Code §2290.5(a)(6)
O. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
P. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
Q. Department of Health Care Services All Plan Letter (APL) 21-006: Network Certification Requirements
R. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
S. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal
Revised	TBD	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
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, 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 Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), 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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

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Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Center (FQHC)	An entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
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.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details.
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Medical Record	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.

For 20220305 Service

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.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
Rural Health Clinic (RHC)	An entity defined in Title 22 CCR Section 51115.5.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 20220303 Review Only

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

For 20220303 BOD Review for Retirement

Summary of changes to Policy GG.1665: Telehealth and Other Technology-Enabled Services

Below is a list of substantive changes to the policy, which are reflected in the attached reline. This list does not include non-substantive changes that may also be reflected in the redline (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

Policy Pages, Section, and Line	Proposed Changes	Rationale	Impact of Change
Page 1, Section II. C. Line 18-21	Added "CalOptima and Health Networks may use Telehealth Providers when they are unable to meet time or distance standards and to increase the network capacity when submitting Alternative Access standard (AAS) requests…."	Updated to reflect the use of telehealth as an alternative means of access	No fiscal impact.
Page 2, Section II. M. Line 37-39	Added "During a public health emergency limiting in-person contact, CalOptima and Health Network providers shall implement telephonic and/or video visits in place of face-to-face interactions according to Member need and preference and to mitigate disease transmission."	Updated to define conditions for telehealth services	No fiscal impact.
Page 1, Section II. N. Lines 41-43	Added "CalOptima or a Health Network shall ensure Qualified Providers utilize secure video conferencing and evidence-based digital tools as a supplement to in-person visits, as appropriate…."	Updated to add requirement to use secure video conferencing for telehealth services	No fiscal impact.
Page 8, Section IX. Line 2 Glossary	Updated Glossary to: • Add California Advancing and Innovating Medi-Cal (CalAIM) Initiative, Enhanced Care Management Requirements and Community Supports under Covered Services • Update definition of Federally Qualified Health Center	Endure appropriate definitions	No fiscal impact

Continued to a Future Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

16. Approve New CalOptima Policy GG.1666 PP: Mobile Texting

Contacts

Richard Pitts, Chief Medical Officer, (714) 347-5750
Marie Jeannis, RN, Executive Director, Quality & Population Health Management, (714) 246-8591

Recommended Action

Approve new CalOptima Policy GG.1666 PP: Mobile Texting policy, in accordance with all regulatory requirements.

Background

In May 2020, the CalOptima Board of Directors authorized CalOptima to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor, as part of CalOptima's Virtual Care Strategy to address timely access to care during the COVID-19 pandemic. CalOptima originally used mobile texting to support COVID-19 related member outreach and engagement. The use of mobile texting has been successful in getting information quickly to members about the availability of COVID-19 vaccines, boosters, and vaccine events. CalOptima continues to expand the use of mobile texting to strengthen member outreach, engagement, support health promotion, education, and preventive care messaging.

Discussion

CalOptima establishes new policies and procedures to implement Federal and State laws, programs, regulations, contacts, and business practices. Additionally, CalOptima staff performs an annual policy review to add or update internal policies and procedures to ensure compliance with applicable requirements.

The new policy ensures the processes and procedures for the mobile texting program are in compliance with the Telephone Consumer Protection Act (TCPA), Health Insurance Portability and Accountability Act (HIPAA), Department of Health Care Services (DHCS) Texting Program and Texting Campaign requirements, and all regulatory, contractual, and operational guidelines.

Fiscal Impact

The recommended action to approve GG.1666 PP is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations, staff recommends that the Board of Directors approve and adopt CalOptima Policy GG.1666 PP: Mobile Texting.

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Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Substantive Areas Policy GG.1666 P:P Mobile Texting
2. Policy GG.1666 PP: Mobile Texting
3. Previous Board Action May 7, 2020, COBAR: Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Substantive Change Areas: New CalOptima Policy GG.1666 PP: Mobile Texting

Below is a list of substantive changes areas in the policy. There is no redlined document available, as this is a new policy.

Policy Section	Proposed Changes	Rationale	Impact
All	Establish new policy for mobile texting campaigns.	Creates an internal policy that define processes and procedures for the mobile texting program and ensure compliance with all regulatory, contractual, and operational guidelines.	No fiscal impact.
Section I. Purpose	This policy describes the CalOptima Mobile Texting Program for Medi-Cal Members	N/A	No fiscal impact
Section II. Policy	This section describes the goals, criteria, and compliance for CalOptima Mobile Texting Program.	N/A	No fiscal impact
Section III. Procedure	This section compliance, consent, and regulatory requirements.	N/A	No fiscal impact
Section IV. Attachments	DHCS Texting Program & Campaign Submission Form / Text Messaging Campaign Indemnification Agreement (October 2020)	Forms that must be completed and submitted to DHCS for review and approval.	No fiscal impact

Policy:	GG.1666PP
Title:	**CalOptima Mobile Texting Program**
Department:	Medical Management
Section:	Population Health Management
Interim CEO Approval:	
Effective Date:	TBD
Revised Date:	
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220303 BOD Review Only

I. PURPOSE

This policy describes the CalOptima Mobile Texting Program for Medi-Cal Members.

II. POLICY

A. The CalOptima Mobile Texting Program aims to strengthen communication outreach opportunities to Members through Mobile Health Interactive Text Messaging Services. CalOptima's Texting Program aims to achieve the following goals:

1. Deliver useful health promotion, prevention, and emergency messaging;
2. Promote healthy behaviors among Members (including preventative care visits);
3. Facilitate behavior change;
4. Provide support through impactful media (including supporting statewide regulatory efforts);
5. Promote wellness and preventive care, including in support of Healthcare Effectiveness Data and Information Set (HEDIS) measures;
6. Improve clinical outcomes;
7. Encourage adherence to recommended care practices; and
8. Serve as an alternative or support to common modalities to Members including mail or telephone outreach.

B. The CalOptima Mobile Texting Program text messages are:

1. Conducted in compliance with the Telephone Consumer Protection Act (TCPA), the Health Insurance Portability and Accountability Act (HIPAA), and applicable regulatory and contractual requirements;

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2. Sent to Members only after CalOptima receives approval from the California Department of Health Care Services (DHCS) to implement a Text Message Campaign;

3. Approved by a Qualified Health Educator (for general health education messages) in accordance with CalOptima Policy GG.1206Δ: Readability and Suitability of Written Health Education Materials;

4. Provided to Members at or below the sixth-grade reading level, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services;

5. Sent in the Member's preferred Threshold Language;

6. Sent when CalOptima call center staff is available to support Member inquiries, but never between the hours of 9 p.m. and 8 a.m.;

7. Not used to conduct any marketing outreach to non-members for the purpose of potential enrollment;

8. Sent to Members for whom CalOptima has verified as eligible with the CalOptima Medi-Cal program based on the review of the monthly 834 file and from whom CalOptima has obtained prior express consent as described in Section III.A. of this Policy. CalOptima may only send text messages to Members without evidence of prior express consent when such automated texts messages are necessary to protect the health and safety of citizens pursuant to the TCPA "Emergency Purposes" exception.;

   a. For text messages related to renewals, sent only to Members on the monthly 834 file with an HCP status of "05" and from whom CalOptima has obtained prior express consent as described in Section III.A. of this Policy; and

   b. CalOptima shall not use the data on the monthly 834 files to send welcome messages to Members for the purpose of collecting prior express consent.

9. Reviewed for compliance with Health Insurance Portability and Accountability Act (HIPAA), the HIPAA Security Rule, and CalOptima Policy HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations. CalOptima shall not send messages that contain Protected Health Information (PHI) or Personal Identifying Information (PII)

C. A Health Network shall submit all Member Health Education Materials, including Health Education Texting Campaigns, to the CalOptima Health Education Department for readability and suitability review and DHCS approval prior to distribution to Members in accordance with this Policy and CalOptima Policy GG.1206Δ: Readability and Suitability of Written Health Education Materials.

III. PROCEDURE

A. In compliance with TCPA guidelines, CalOptima shall obtain prior express consent from a Member to participate (i.e., Member consent, release of information) in the CalOptima Mobile Texting Program as follows:

1. Written consent for Members mailed the mobile texting member consent form with pre-paid business reply envelope;

2. Written consent for Members accessing CalOptima's Member portal and completion of communications preferences; or

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3. Documented verbal consent for Members dialing into any CalOptima call center (Customer Service, Population Health Management, and Behavioral Health Integration);

4. CalOptima is not required to obtain prior express consent from a Member for texting campaigns that are for "Emergency Purposes" as defined by the TCPA.

    a. "Emergency Purposes" includes calls made necessary in any situation affecting the health and safety of consumers. The "Emergency Purposes" exception is intended for "instances [that] pose significant risks to public health and safety, and [where] the use of prerecorded message calls could speed the dissemination of information regarding potentially hazardous conditions to the public."

    b. The caller must be from a hospital, or be a health care provider, state or local health official, or other government official as well as a person under the express direction of such an organization and acting on its behalf. The content of the call must be solely informational.

    c. In order to qualify for the emergency exemption, the caller must be from a hospital, or be a health care provider, state or local health official, or other government official, or as a person under the express direction of such an organization and acting on its behalf, and the message delivered must be informational only, made necessary by the situation affecting the health and safety of Members, and directly related to the imminent risk created by the situation affecting the health and safety of Members.

B. DHCS Texting Program and Texting Campaign Requirements

1. For a new Mobile Texting Program, CalOptima shall submit all required elements of the DHCS Texting Program & Campaign Submission Form as well as a signed Text Messaging Campaign Indemnification Agreement to DHCS for review and approval at least sixty (60) calendar days prior to the proposed start date of the CalOptima Mobile Texting Program (Attachment A).

2. For an additional individual Mobile Texting Campaign and upon approval by DHCS of the Texting Program, CalOptima shall complete only Section A and Section C of Attachment A as well as submit a signed Text Messaging Campaign Indemnification Agreement.

C. To protect data costs incurred by Members and to fully inform Members of such possible costs, Members will receive one (1) Free to End User (FTEU) message through a special short code to welcome them to the CalOptima Mobile Texting Program. This welcome message:

1. Is sent at no charge to the Member;

2. Informs the Members that message charges (depending on their data plan) may apply to future text messages; and

3. Notifies Members that they can opt-out of the program with a "STOP" reply to the welcome message at no charge to the Member. Once a Member replies "STOP," a confirmation message will be sent out at no charge to the Member. If a Member does not reply "STOP," the Member will continue to receive text messages from CalOptima.

D. Members may opt-out of the CalOptima Mobile Texting Program at any time by replying "STOP" or by contacting CalOptima Customer Service at 1-888-587-8088 Toll-free or TTY: 711. The CalOptima Customer Service Department shall immediately update a Member's record in the FACETS system upon a Member's call requesting to opt-out.

For 20220302 BOD Review Only

1. For opt-out requests received by a third-party mobile texting vendor, the vendor shall indicate the phone number as an opt-out in the daily files submitted to CalOptima. CalOptima shall update the Member record in the FACETS systems the next business day and the Member will be removed from the CalOptima Mobile Texting Program until such time as the Member changes his or her consent status with CalOptima.

2. Prior to initiating a Mobile Texting Campaign, CalOptima shall validate identified Members' phone numbers against FACETS systems for opt-out status.

E. For Members who are minors, CalOptima will send text messages to the minor's parent(s), legal guardian, or other Personal Representative. To address custody/guardianship/parent situations, CalOptima will verify the appropriate Personal Representative using information available, including DHCS member eligibility files and Member-reported information.

F. CalOptima shall document a Member's consent response to include the date consent is received from the Member in the FACETS system. Updates to a Member's consent status will be tracked and recorded in the FACETS system. CalOptima shall use the consent received for the most recent date to initiate a Mobile Texting Campaign to targeted populations.

G. Any third-party vendor contract/business agreement used to conduct texting on behalf of CalOptima will be submitted to DHCS for approval. Vendor contract must adhere to DHCS policies, procedures, contract, and regulatory requirements.

H. For ongoing texting campaigns, CalOptima shall submit outcome data for mobile texting campaigns on an annual basis to DHCS forty-five (45) calendar days from the annual anniversary of the initiation of the campaign. For programs that are time limited, CalOptima shall submit outcome data to DHCS six (6) months after a campaign ends.

I. CalOptima and its Business Associates shall apply appropriate Sanctions against its Business Associates where there has been a violation of compliance with HIPAA, as amended, and the regulations promulgated thereunder, and/or CalOptima privacy and security policies up to, and including termination of contracts, as applicable and in accordance with CalOptima Policy HH.2002Δ: Sanctions.

IV. ATTACHMENT(S)

A. DHCS Texting Program & Campaign Submission Form / Text Messaging Campaign Indemnification Agreement (October 2020)

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy DD.2002: Cultural and Linguistic Services
C. CalOptima Policy GG.1206Δ: Readability and Suitability of Written Health Education Materials
D. CalOptima Policy HH.2002Δ: Sanctions
E. CalOptima Policy HH.3011Δ: Use and Disclosure of PHI for Treatment, Payment, and Health Care Operations. *CalOptima shall not send messages that contain Protected Health Information (PHI) or Personal Identifying Information (PII)*
F. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-016: Readability and Suitability of Written Health Education Material
G. Title 45, Code of Federal Regulations (C.F.R.), Part 160 and Part 164 (subparts A and C)
H. Telephone Consumer Protection Act

VI. REGULATORY AGENCY APPROVAL(S)

For 20220303 BOD Review Only

Date	Regulatory Agency
03/03/2021	Department of Health Care Services

VII. BOARD ACTION(S)

Date	Meeting

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	TBD	GG.1666	CalOptima Mobile Texting Program	Medi-Cal

For 20220303 BOD Review Only

IX. GLOSSARY

Term	Definition
Business Associates	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. A person or entity who: 1. On behalf of such Covered Entity or of an organized health care arrangement (as defined in this section) in which the Covered Entity participates, but other than in the capacity of a Member of the Workforce of such Covered Entity or arrangement, creates, receives, maintains, or transmits protected health information for a function or activity regulated by this subchapter, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, patient safety activities listed at 42 CFR 3.20, billing, benefit management, practice management, and repricing; or 2. Provides, other than in the capacity of a Member of the Workforce of such Covered Entity, legal, actuarial, accounting, consulting, data aggregation (as defined in §164.501 of this subchapter), management, administrative, accreditation, or financial services to or for such Covered Entity, or to or for an organized health care arrangement in which the Covered Entity participates, where the provision of the service involves the Disclosure of protected health information from such Covered Entity or arrangement, or from another Business Associate of such Covered Entity or arrangement, to the person. A Covered Entity may be a Business Associate of another Covered Entity. Business Associate includes: 1. A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a Covered Entity and that requires access on a routine basis to such protected health information. 2. A person that offers a personal health record to one or more individuals on behalf of a Covered Entity. 3. A subcontractor that creates, receives, maintains, or transmits protected health information on behalf of the Business Associate.
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.
Downstream Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with persons or entities involved with a CalOptima Program benefit, below the level of the arrangement between CalOptima and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

For 20220303 BOD Review Only

Term	Definition
Emergency Purposes	Calls made necessary in any situation affecting the health and safety of consumers. The caller must be from a hospital, or be a health care provider, state or local health official, or other government official as well as a person under the express direction of such an organization and acting on its behalf. The content of the call must be solely informational, made necessary by the situation affecting the health and safety of Members, and directly related to the imminent risk created by the situation affecting the health and safety of Members.
FDR	First Tier, Downstream or Related Entity, as separately defined herein.
First Tier Entity	Any party that enters into a written arrangement, acceptable to DHCS and/or CMS, with CalOptima to provide administrative services or health care services to a Member under a CalOptima Program.
Health Education Materials	Materials designed to assist Members to modify personal health behaviors, achieve and maintain healthy lifestyles, and promote positive health outcomes, includes updates on current health conditions, self-care, and management of health conditions. Topics may include messages about preventive care, health promotion, screenings, disease management, healthy living, and health communications.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy, and security of health information, and as subsequently amended.
Health Network	A Health Network is 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.
HIPAA Security Rule	National standards to protect individuals' electronic personal health information that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical, and technical safeguards to ensure the confidentiality, integrity, and security of electronic protected health information.
Healthcare Effectiveness Data and Information Set (HEDIS)	A set of standardized performance measures designed to provide purchasers and consumers with relevant information on health plan performance and facilitate the comparison of managed care organizations. HEDIS is sponsored, supported, 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.
Mobile Texting Campaign	Specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).
Mobile Texting Program	Overall program design and infrastructure utilized to implement individual text messaging campaigns.

For 2022/03 POD review Only

Term	Definition
Personal Representative	Has the meaning given to the term Personal Representative in section 164.502(g) of title 45 of, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors and as further described in CalOptima Policy HH.3009Δ: Access, Use, and Disclosure of PHI to a Member's Personal Representative.
Personally Identifiable Information (PII)	Any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information.
Protected Health Information (PHI)	Has the meaning 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.
Qualified Health Educator	A qualified health educator is defined as a health educator with one (1) of the following qualifications: 1. Master of Public Health (MPH) degree with a health education or health promotion emphasis; 2. Master's degree in community health with a specialization in health education or health promotion; or 3. MCHES (Master Certified Health Education Specialist) awarded by the National Commission for Health Education Credentialing, Inc.
Related Entity	Any entity that is related to CalOptima by common ownership or control and that: performs some of CalOptima's management functions under contract or delegation; furnishes services to Members under an oral or written agreement; or leases real property or sells materials to CalOptima at a cost of more than $2,500 during a contract period.
Sanction	An action taken by CalOptima, including, but not limited to, restrictions, limitations, monetary fines, termination, or a combination thereof, based on an FDR's or its agent's failure to comply with statutory, regulatory, contractual, and/or other requirements related to CalOptima Programs.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA).

1

For 20220505 BOD Review Only

Continued to a Future Meeting

TEXTING PROGRAM & CAMPAIGN SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New MemberOrientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_MultipleCampaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only. The exception to this is if the MCP has already received approval on an emergency text campaign. These campaigns only require a one-time submission and approval.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

For 20220303 BOD Review Only

SECTION A: GENERAL INFORMATION

1. Managed Care Plan:_____ Date: ____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

_____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

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If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

For 20220303 BOD Review Only

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI andmeet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federallaw and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

For 20220303 BOD Review Only

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
   a. Providing health education information
   b. Providing written member information
   c. Reminding of preventive care visits
   d. Supporting statewide regulatory efforts on digital communications
   e. Emergency Messaging
   f. Other(s): _____

   Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

   Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

   ☐ Yes
   ☐ No

   If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

   ☐ Yes
   ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

   ☐ Yes
   ☐ No

For 20220303 BOD Review Only

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

For 20220303 BOD Review Only

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

For 20220303 BOD Review Only

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] [INSERT NAME OF TEXT MESSAGING CAMPAIGN] [INSERT TYPE OF CAMPAIGN eg., Call Campaign, texting campaign], [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of 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 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

[INSERT HEALTH PLAN NAME] also agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred from claims that the mobile application caused cellular data usage overages as a result of downloading, updates or usage of [INSERT HEALTH PLAN NAME]'s text messaging campaign.

[INSERT HEALTH PLAN NAME also agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred from claims that [INSERT HEALTH PLAN NAME]'s [INSERT NAME OF TEXT MESSAGING CAMPAIGN] [INSERT TYPE OF CAMPAIGN eg., Call Campaign, texting campaign] violates the Telephone Consumer Protection Act of 1991, 47 U.S.C. section 227 et seq. and/or related Federal Communications Commission regulations.

For 20220303 BOD Review Only

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Virtual Care Strategy and Roadmap as Part of Coronavirus Disease (COVID-19) Mitigation Activities and Contract with Mobile Health Interactive Text Messaging Services Vendor

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Approve Virtual Care Strategy and Roadmap;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to contract with vendor mPulse Mobile, a Mobile Health Interactive Text Messaging Services vendor; and
3. Approve the recommended allocation of intergovernmental transfer (IGT) 9 funds not to exceed $3.9 million for a three-year period to provide a text messaging solution for all CalOptima member communications.

Background

As the Coronavirus Disease (COVID-19) continues to spread and threatens lives of many vulnerable populations, the COVID-19 pandemic has created an urgency for CalOptima and other Managed Care Plans (MCPs) to expand their virtual care strategy immediately to ensure timely access to care for our members and support our providers' use of virtual care during the strict social distancing measures while providers experience shortages of Personal Protective Equipment (PPE).

As a result of the COVID-19 pandemic, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements.

At its April 2, 2020 meeting, the CalOptima Board of Directors ratified various COVID-19 mitigation activities. In addition to the approval of Telehealth Policies and Procedures to include temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements in the event of a health-related national emergency, the Board authorized contracting with Virtual Care Consultant Sajid Ahmed of WISE Healthcare to help expedite the deployment of the CalOptima Virtual Care Strategy and Roadmap.

At the same meeting, the Board approved the recommended allocation of IGT 9 funds in the amount of $45 million for initiatives within four focus areas: member access and engagement, quality performance, data exchange and support and other priority areas. At that time, the Board approved five initiatives totaling $40.5 million. Staff would return to the Board with recommendations for allocating the remaining $4.5 million towards member access and engagement.

Discussion

In addition to the actions approved in response to COVID-19 to date, management recommends that the Board authorize the implementation of virtual care services for members and providers with long term implications beyond the COVID-19 pandemic.

Virtual Care Strategy and Roadmap

As the sophistication and simplification of mobile technology has evolved over time beyond telehealth, virtual care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring, and treatment. CalOptima staff cites to an adopted virtual care definition as "any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care." [1]

CalOptima management plans to continue to use the term "telehealth" to include member materials approved by DHCS in order to be consistent with DHCS All Plan Letter (APL) 19-009: Telehealth Services Policy.

CalOptima's main Virtual Care Strategies include the following elements. Staff will return to the Board to seek authority for approval of implementation of the Virtual Care Strategies through specific vendors and initiatives in the future:

1. Support CalOptima's contracted providers' use of virtual visits during COVID-19 and beyond [all members]
    a. Technical assistance and operational support
    b. CalOptima virtual care team
    c. HIPAA compliant platform(s)
2. Contract with specialty providers with a virtual care focus for CCN members.
    a. Provider(s)/vendor(s) to treat chronic pain/opioid dependency, and provide medication assisted treatment, and eating disorder treatment
    b. Other specialties as available
3. Contract with a vendor offering virtual visits including after-hour access for all CalOptima members regardless of network assignment for acute non-emergency medical conditions and behavioral health conditions through its own provider network
    a. Integrate with CalOptima website and/or member portal
    b. Technical support for members
    c. Integrate with existing nurse advice line
    d. Develop member smartphone app
4. Contract with a vendor offering eConsults for CCN members and PCP's through CalOptima contracted specialists who wish to participate and/or its own provider network
    a. Technical assistance and operational support for CCN providers
    b. Integrate with CCN UM process
    c. Integrate with CCN provider portal
5. Member texting
    a. Via CalOptima member smartphone app

With these proposed Virtual Care Strategies, CalOptima staff believes that virtual care can bring immediate short-term benefits:

- Improved member access and convenience;
- Reduced avoidable in person visits to specialists; and
- Decreased wait time for specialty visits by members.

CalOptima staff is also expecting positive long-term outcomes as a result of implementing virtual care:

- Improved member experience;
- Augmented network capacity and adequacy; and
- Improved clinical quality outcomes.

As recommended by staff, CalOptima's Virtual Care Strategy proposes a detailed logic model and a work plan which are included in the attachments (refer to Attachment 3 and Attachment 4).

Proposal to Implement Mobile Health Interactive Text Messaging Services

CalOptima currently uses traditional modes of member communication, including telephonic, print and mail. CalOptima staff seeks to strengthen communication outreach opportunities to our members through Mobile Health Interactive Text Messaging Services that will:

- Deliver useful health promotion and prevention messaging;
- Promote healthy behaviors among members;
- Facilitate behavior change;
- Provide support through impactful media;
- Promote wellness and preventive care including Healthcare Effectiveness Data and Information Set (HEDIS) measures;
- Improve clinical outcomes; and
- Encourage adherence to recommended care practices

CalOptima's RFP minimum requirements for the mobile texting vendor include the following:

- Provide Mobile Text Messaging services to enhance member engagement by supporting CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.
- Deliver technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.
- Ensue that content written at a sixth grade reading level or below so that the information is easy to understand.
- The Platform must be a Health Insurance Portability and Accountability Act (HIPAA) compliant platform with secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data.

Through a Request for Proposal (RFP) process conducted in 2019, CalOptima staff received eight (8) responses and with two finalist texting solution vendors, HealthCrowd and mPulse Mobile (mPulse). CalOptima's Mobile Texting RFP Selection workgroup is recommending that the Board authorize a

contract with mPulse based on it receiving the highest evaluation score (refer to Attachment 5) mPulse specializes in Conversational Artificial Intelligence (AI) solutions for the healthcare industry and promotes improved health outcomes by engaging individuals with tailored and meaningful dialogue. mPulse combines behavioral science, analytics and industry expertise to help healthcare organizations promote their members acquiring healthy behaviors. mPulse is HIPAA and Telephone Consumer Protection Act (TCPA)-compliant, and Health Information Trust (HITRUST) Alliance-certified.

CalOptima's Mobile Texting RFP Selection workgroup is recommending Board authorization for a contract of three years in an amount not to exceed $3,900,000. Based on the CalOptima membership, the estimated annual cost for the contract is approximately $1,000,000, with a separate expense of $80,256 for implementation and set-up. Staff recommends allocating IGT 9 funding not to exceed $3.9 million under the Board-approved focus area of Member Access and Engagement. In addition, staff recommends entering into further negotiations and pursing a contract with mPulse with the assistance of CalOptima's Procurement and Legal Departments.

As discussed at prior CalOptima Board meetings, IGT 9 dollars are accounted for in the same fashion as the Medi-Cal capitation revenue CalOptima receives from the DHCS in that, to the extent that these funds are not expended on covered, medically necessary Medi-Cal services or qualifying quality initiatives, the expenditures would be charged to CalOptima's General and Administrative categories, which are included in administrative loss ratio (ALR).

DHCS requires MCPs to submit a texting program and/or its individual texting campaign approval form to the state. DHCS will review and respond within 60 days of submission of the form (See Attachment 7).

As indicated, staff will return to the Board to seek authority for approval of other elements of the Virtual Care Strategy in the future.

Fiscal Impact

The recommended action to approve the Virtual Care Strategy and Roadmap has no additional fiscal impact for Fiscal Year (FY) 2019-20. Staff will address new virtual care strategies including a vendor offering 24/7 virtual visits and a vendor offering eConsults in future board reports and recommended actions.

The recommended action to select and contract with mPulse, a mobile health interactive text messaging services vendor has no net fiscal impact to CalOptima's operating budget over the proposed project term. Staff estimates that IGT 9 revenue from DHCS will be sufficient to cover the allocated expenditures for the initiative recommended in this report.

Rationale for Recommendation

The recommended actions are important steps in enabling CalOptima to provide additional access to quality care for our members and providers during and after the pandemic.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated April 2, 2020, Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities
2. CalOptima Virtual Care Roadmap Presentation
3. Virtual Care Strategy Logic Model
4. Virtual Care Strategy Work Plan
5. 19-20 Texting RFP Final Team Evaluation Summary Scoring Criteria
6. Texting Program RFP Scope of Work
7. DHCS Texting Program & Campaign Submission Form
8. Board Action dated February 7, 2019, Consider Approval of CalOptima Population Health Management Strategy for 2019
9. Entities Covered by this Recommended Board Action

Reference
1. Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

/s/ Richard Sanchez *04/29/2020*
Authorized Signature **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2020
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Ratification of Coronavirus Disease (COVID-19) Mitigation Activities

Contact

David Ramirez, M.D., Chief Medical Officer, Medical Management, 714-246-8400
Betsy Ha, Executive Director, Quality and Population Health Management, 714-246-8400

Recommended Actions

1. Ratify CalOptima Medi-Cal Policy GG.1665: Telehealth and Other Technology-Enabled Services and Medicare Policy MA.2100: Telehealth and Other Technology-Enabled Services and authorize Staff to update the COVID-19 addendums to such policies on an ongoing basis, as necessary and appropriate to align with new government waivers and guidance;
2. Ratify contracts with a virtual care expert consultant to assess and assist with CalOptima's virtual care strategy;
3. Ratify contracts with medical consultants to assist with CalOptima's response to the COVID-19 situation; and
4. Authorize reallocation of budgeted but unused funds of $20,000 from the Professional Fees budget to fund the contracts with medical consultants.

Background/Discussion

Telehealth Policies and Procedures (P&Ps)

One of CalOptima's primary strategic priorities is to expand the Plan's member-centric focus and improve member access to care by using telehealth (also known as virtual care) to fill gaps in provider networks and meet network certification requirements. CalOptima would like to improve member experience by incorporating new modalities to make it more convenient for members to access care on a timely basis. In addition to better assisting our members, we believe telehealth can increase value and improve care delivery by deploying innovative delivery models.

In addition, as the new novel coronavirus has emerged and continues to spread around the United States (COVID-19 Crisis), it has become more imminent that CalOptima needs to establish telehealth (virtual care) services as soon as possible to ensure safe access to care for our community, members and providers.

As a result of the COVID-19 Crisis, the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) have been issuing guidance addressing Medi-Cal and Medicare telehealth options and requirements including, DHCS All-Plan Letter (APL) 19-009: Telehealth, APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic and CMS' telehealth guidelines, The U.S. Department of Health and Human Services, Office for Civil Rights, has also provided guidance related to relaxation of certain enforcement actions for use of technology platforms that may not be HIPAA-complaint but are used in providing telehealth covered services curing the COVID-19 crisis.

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Medi-Cal and Medicare telehealth guidelines differ in some respects such that CalOptima has developed separate Medi-Cal and Medicare policies. These policies include addendums addressing criteria and requirements that are waived during the COVID-19 Crisis. Since government waivers and guidance are fluid, staff also seeks Board authority to update telehealth guidance on the COVID-19 crisis as necessary and appropriate.

Medi-Cal Telehealth Policy

CalOptima's GG.1665: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement for Medi-Cal Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations and DHCS guidance;

- CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements;

- Requirements that Qualified Providers must comply with when using Telehealth to furnish Covered Services including, but not limited to Member consent, confidentiality, setting, and documentation requirements;

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS APL 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

- In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements.

The addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 Crisis.

Medicare Telehealth Policy

CalOptima's MA.2100: Telehealth and Other Technology-Enabled Services Policy addresses coverage, billing, coding and reimbursement requirements for Medicare Telehealth and Other Technology-Enabled Covered Services including:

- CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

- CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth including, but not limited to:

    - CalOptima Members may receive Medicare Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

    - Covered Services normally furnished on an in-person basis to Members and included on the CMS List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

    - For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

    - Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

- The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission as more particularly described in the Policy.

- Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

- In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. The Addendum attached to this Policy contains information related to health-related national emergency waivers and specifically those applicable to the COVID-19 crisis.

Virtual Care Expert Consultant

Virtual care is the use of digital information and communication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. CalOptima desires to improve member's access to care by using virtual modalities to fill gaps in provider networks.

Since the release of DHCS APL 19-009: Telehealth Services Policy, CalOptima concluded that the organization needs to create a broader virtual care strategy that includes telehealth and other virtual modalities (e.g., virtual provider network).

CalOptima currently does not have staff with virtual care expertise and its executives decided to bring in a consultant with subject matter expertise with Medi-Cal managed care operational and delegated model experiences in the virtual care space.

The consultant is committed to provide strategic planning and coordination, meeting the following milestones:

- A review of past attempts CalOptima has made toward developing a telehealth strategy by March 30, 2020
- Assessment of CalOptima's proposed virtual care strategy by April 15, 2020
- A gap analysis between what currently exists, cross-functional dependency processes and the virtual care strategy implication by April 30, 2020
- Provide recommendations to fill gaps in the current care delivery system leveraging virtual care modalities by May 1, 2020
- Vet the recommendations with stakeholders by May 15, 2020
- Develop an implementation workplan for a vendor to implement the recommendations by June 30, 2020
- Provide virtual care recommendations related to emergency situations as needed to address the COVID-19 crisis until June 30, 2020

In order to meet the milestones below, CalOptima staff recommends ratification of the contract with virtual care consultant to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT SCHEDULE

Milestone	**Completion Date**	**Fee**
Review Past Telehealth Attempts	March 30, 2020	$3,500
Assessment of Virtual Care Strategy	April 17, 2020	$10,500
Gap Analysis	May 1, 2020	$21,000

Provide Recommendations	May 15, 2020	$21,000
Vet Recommendations to Stakeholders	May 15, 2020	$21,000
Present Plan to CalOptima Board on June 4, 2020	June 4, 2020	$3,500
Develop Implementation Workplan	June 30,2020	$14,350
TOTAL		**$94,850**

Medical Consultants in Response to COVID-19 Situation
On March 11, 2020, the World Health Organization (WHO) officially declared COVID-19 as a pandemic. California's governor also declared a state of emergency over COVID-19 in the state, while the situation has moved from containment phase to mitigation phase with documented community spread.

As the COVID-19 mitigation phase activities intensify with increasing demand for daily identification and reporting of cases to the DHCS and Orange County Health Care Agency (OC HCA), it became critical that CalOptima address its two vacant Medical Directors to support Chief Medical Officer (CMO) and provide timely direction to providers.

While Dr. Miles Masatsugu, one of CalOptima's Medical Directors, has done a tremendous job as a clinical leader and a point of contact during the containment phase, he now needs to direct his attention to CalOptima's PACE members who are considered the highest risk population. Therefore, the Plan's executives decided to bring in medical consultants immediately to help the CMO mitigate the spread of COVID-19.

The medical consultants are committed to providing the following professional consultant services:

- Oversee daily COVID-19 reporting to DHCS;
- Gather and review COVID-19 related information and make recommendations related to members, staff, providers and health networks for CalOptima leadership's considerations;
- Review and provide updates on daily information regarding the spread of COVID-19 including WHO, Centers for Disease Control and Prevention (CDC), DHCS, California Public Health Agency, OC HCA, and OC Public Health Laboratory;
- Collaborate as clinical leads on COVID-19 related projects and initiatives;
- Support CMO to prepare for COVID-19 responses in coordination with OC HCA; and
- Support CMO with additional duties related to COVID-19 containment as needed.

In order to provide accurate and timely recommendations and responses amid COVID-19, CalOptima staff recommends ratification of contracts with medical consultants to address the COVID-19 Crisis and ensure safety of our members, providers, community and staff.

PAYMENT INFORMATION

- $10,000 for each medical consultant
- Total: $20,000

Fiscal Impact

The recommended action to ratify CalOptima Policies GG.1665 and MA.2100 are operational in nature and does not have a fiscal impact.

The recommended action to ratify a contract with a virtual care expert consultant is a budgeted capital item. Funding of $100,000 is included under Telehealth Professional Fees as part of the CalOptima Fiscal Year 2019-20 Capital Budget approved on June 6, 2019.

The recommended action to ratify contracts with medical consultants for an amount not to exceed $20,000 is an unbudgeted item and budget neutral. Unspent budgeted funds from professional fees budget approved in the CalOptima FY 2019-20 Operating Budget on June 6, 2019, will fund the total cost of up to $20,000.

Rationale for Recommendation

The recommended actions will enable CalOptima to be compliant with telehealth requirements and address the COVID-19 public health crisis.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. Entities Covered by this Recommended Action
2. GG.1665: Telehealth and Other Technology-Enabled Services P&P
3. MA.2100: Telehealth and Other Technology-Enabled Services P&P
4. APL 19-009: Telehealth
5. APL 19-009 Supplement: Emergency Telehealth Guidance - COVID-19 Pandemic
6. Virtual Care Consultant Résumé (Sajid Ahmed)
7. Medical Consultant Résumé (Dr. Peter Scheid)
8. Medical Consultant Résumé (Dr. Tanya Dansky)

/s/ Michael Schrader — *03/26/2020*

Authorized Signature — **Date**

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Sajid Ahmed	1300 Prospect Drive	Redlands	CA	92373
Tanya Dansky M.D.	3030 Children's Way	San Diego	CA	92123
Peter Scheid M.D.	17 Calle Frutas	San Clemente	CA	92673

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Policy:	GG.1665
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative - Internal ☐ Administrative – External

For 20200402 BOD Review Only

I. PURPOSE

This policy sets forth the requirements for coverage and reimbursement of Telehealth Covered Services rendered to CalOptima Medi-Cal Members.

II. POLICY

A. Qualified Providers may provide Medi-Cal Covered Services to Members through Telehealth as outlined in this Policy and in compliance with applicable statutory, regulatory, contractual requirements, and Department of Health Care Services (DHCS) guidance.

B. CalOptima and its Health Networks shall ensure that Covered Services provided through Telehealth are rendered by Qualified Providers who meet appropriate licensing and regulatory requirements as provided in Section III.A. of this Policy and in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners, and GG.1605: Delegation and Oversight of Credentialing or Recredentialing Activities prior to providing services to any Member.

C. Qualified Providers who use Telehealth to furnish Covered Services must comply with the following requirements:

1. Obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services;

2. Comply with all state and federal laws regarding the confidentiality of health care information;

3. Maintain the rights of CalOptima Members access to their own medical information for telehealth interactions;

4. Document treatment outcomes appropriately; and

5. Share records, as needed, with other providers (Telehealth or in-person) delivering services as part of Member's treatment.

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D. Members shall not be precluded from receiving in-person Covered Services after agreeing to receive Covered Services through Telehealth.

E. CalOptima and its Health Networks shall not require a Qualified Provider to be present with the Member at the Originating Site unless determined Medically Necessary by the provider at the Distant Site.

F. CalOptima or a Health Network shall not limit the type of setting where Telehealth Covered Services are provided to the Member.

G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, DHCS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. CalOptima and its Health Networks may use Telehealth to satisfy network adequacy requirements as outlined in DHCS All Plan Letter (APL) 20-003: Network Certification Requirements, as well as any applicable DHCS guidance.

J. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medi-Cal Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medi-Cal laws, regulations, and other guidance, and the requirements set forth in this Policy.

K. In the event of a health-related national emergency, DHCS may request, and CMS may grant temporary waivers regarding Telehealth or Other Technology-Enabled Services requirements. Please see addenda attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Qualified Providers furnishing Covered Services through Telehealth must inform the Member about the use of Telehealth and obtain verbal or written consent from the Member for the use of Telehealth as an acceptable mode of delivering health care services.

2. Qualified Providers may use a general consent agreement that specifically mentions the use of Telehealth as an acceptable modality for the delivery of Covered Services as appropriate consent from the Member.

3. Qualified Providers must document consent as provided in Section III.D.

B. Qualifying Provider Requirements

1. The following requirements apply to Qualified Providers rendering Medi-Cal Covered Services via Telehealth:

a. The Qualified Provider meets the following licensure requirements:

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i. The Qualified Provider is licensed in the state of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP); or

ii. If the Qualified Provider is out of state, the Qualified Provider must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual.

2. The Qualified Provider must satisfy the requirements of California Business and Professions Code (BPC) section 2290.5(a)(3), or the requirements equivalent to California law under the laws of the state in which the provider is licensed or otherwise authorized to practice (such as the California law allowing providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies, to practice as Behavior Analysts, despite there being no state licensure).

3. Qualified Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide Covered Services through Telehealth.

C. Provision of Covered Services through Telehealth

1. Qualified Providers may provide any existing Medi-Cal Covered Service, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing utilization management treatment authorization requirements, through a Telehealth modality if all of the following criteria are satisfied:

a. The treating Qualified Provider at the Distant Site believes the Covered Services being provided are clinically appropriate to be delivered through Telehealth based upon evidence-based medicine and/or best clinical judgment;

b. The Member has provided verbal or written consent in accordance with this Policy;

c. The medical record documentation substantiates the Covered Services delivered via Telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the Covered Service;

d. The Covered Services provided through Telehealth meet all laws regarding confidentiality of health care information and a Member's right to the Member's own medical information; and

e. The Covered Services provided must support the appropriateness of using the Telehealth modality based on the Member's level of acuity at the time of the service.

f. The Covered Services must not otherwise require the in-person presence of the Member for any reason, including, but not limited to, Covered Services that are performed:

i. In an operating room;

ii. While the Member is under anesthesia;

iii. Where direct visualization or instrumentation of bodily structures is required; or

iv. Involving sampling of tissue or insertion/removal of medical devices.

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2. Telehealth Covered Services must meet Medi-Cal reimbursement requirements and the corresponding CPT or HCPCS code definition must permit the use of the technology.

D. Documentation Requirements

1. Documentation for Covered Services delivered through Telehealth are the same as documentation requirements for a comparable in-person Covered Service.

2. All Distant Site providers shall maintain appropriate supporting documentation in order to bill for Medi-Cal Covered Services delivered through Telehealth using the appropriate CPT or HCPCS code(s) with the corresponding modifier as defined in the Medi-Cal Provider Manual Part 2: Medicine: Telehealth and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

3. CalOptima and its Health Networks shall not require providers to:

   a. Provide documentation of a barrier to an in-person visit for Medi-Cal services provided through Telehealth; or

   b. Document cost effectiveness of Telehealth to be reimbursed for Telehealth services or store and forward services.

4. Qualified Providers must document the Member's verbal or written consent in the Member's Medical Record. General consent agreements must also be kept in the Member's Medical Record. Consent records must be available to DHCS upon request, and in accordance with CalOptima Policy GG.1603: Medical Records Maintenance.

5. Qualified Providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered through Telehealth, for both Synchronous Interactions and Asynchronous Store and Forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by CalOptima Members.

E. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

1. FQHC/RHC Established Member

   a. A Member is an FQHC/RHC Established Member if the Member has a Medical Record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous Telehealth visit in a Member's residence or home with a clinic provider and a billable provider at the clinic. The Member's Medical Record must have been created or updated within the previous three (3) years; or,

   b. The Member is experiencing homelessness, homebound, or a migratory or seasonal worker and has an established Medical Record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the service area of the FQHC or RHC; or,

   c. The Member is assigned to the FQHC or RHC by CalOptima or their Health Network pursuant to a written agreement between the plan and the FQHC or RHC.

2. Services rendered through Telehealth to an FQHC/RHC Established Member must comply with Section II.C. of this Policy and be FQHC or RHC Covered Services and billable as documented

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in the Medi-Cal Provider Manual Part 2: Rural Clinics (RHCs) and Federally Qualified Health Centers (FQHCs).

F. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

1. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

2. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

G. Other Technology-Enabled Services

1. E-Consults

a. E-consults are permissible only between Qualified Providers.

b. Consultations via asynchronous electronic transmission cannot be initiated directly by patients.

c. E-consults are permissible using CPT-4 code 99451, and appropriate modifiers, subject to the service requirements, limitations, and documentation requirements of the Medi-Cal Provider Manual, Part 2—Medicine: Telehealth.

2. Virtual/Telephonic Communication

a. Virtual/telephonic communication includes a brief communication with another practitioner or with a patient who cannot or should not be physically present (face-to-face).

b. Virtual/Telephonic Communications are classified as follows:

i. HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within twenty-four (24) hours, not originating from a related evaluation and management (E/M) service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment.

ii. HCPCS code G2012: Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven (7) days nor leading to an E/M service or procedure within the next twenty-four (24) hours or soonest available appointment; 5-10 minutes of medical discussion. G2012 can be billed when the virtual communication occurred via a telephone call.

H. Service Requirements and Electronic Security

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1. Qualified Providers must use an interactive audio, video or data telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site for Telehealth Covered Services.

    a. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

    b. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

2. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of Telehealth transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

I. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1102: Member Grievance, HH.1103: Health Network Member Grievance and Appeal Process, HH.1108: State Hearing Process and Procedures, and GG.1510: Appeals Process.

J. Payments for services covered by this Policy shall be made in accordance with all applicable State DHCS requirements and guidance. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policies FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group and 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.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
C. CalOptima Policy GG.1508: Authorization and Processing of Referrals
D. CalOptima Policy GG.1510: Appeals Process
E. CalOptima Policy GG.1603: Medical Records Maintenance
F. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
G. CalOptima Policy GG.1605: Delegation and Oversight of Credentialing and Recredentialing Activities
H. CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group

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I. 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
J. CalOptima Policy HH.1102: Member Grievance
K. CalOptima Policy HH.1103: Health Network Member Grievance and Appeal Process
L. Manual of Current Procedural Terminology (CPT®), American Medical Association, Revised 2006
M. Department of Health Care Services All Plan Letter (APL) 19-009: Telehealth Services Policy
N. Department of Health Care Services All Plan Letter (APL) 20-003: Network Certification Requirements
O. Medi-Cal Provider Manual Part 1: Medicine: Telehealth
P. Medi-Cal Provider Manual Part 2: Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

VI. REGULATORY AGENCY APPROVAL(S)

Date		Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	GG.1665	Telehealth and Other Technology-Enabled Services	Medi-Cal

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
Border Community	A town or city outside, but in close proximity to, the California border.
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.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.

For 2020 POD Review Only

Term	Definition
FQHC/RHC Established Member	A Medi-Cal eligible recipient who meets one or more of the following conditions: • The patient has a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years. • The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the Originating Site clinic, but within the FQHC's or RHC's service area. All consent for telehealth services for these patients must be documented. • The patient is assigned to the FQHC or RHC by their Managed Care Plan pursuant to a written agreement between the plan and the FQHC or RHC.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
HIS-MOA Clinics	Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, clinics that are participating under the IHS-MOA are not affected by PPS rate determination. Refer to the Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics section in this manual for billing details
Medically Necessary or Medical Necessity	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 must be provided in a way that provides all protections to the Enrollee provided by Medicare and Medi-Cal. Per Medicare, services must be reasonable and necessary 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.
Medical Record	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.

For 2020

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.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	A professional provider including physicians and non-physician practitioners (such as nurse practitioners, physician assistants and certified nurse midwives). Other practitioners, such as certified nurse anesthetists, clinical psychologists and others may also furnish Telehealth Covered Services within their scope of practice and consistent with State Telehealth laws and regulations as well as Medi-Cal and Medicare benefit, coding and billing rules. Qualified Provider may also include provider types who do not have a Medi-Cal enrollment pathway because they are not licensed by the State of California, and who are therefore exempt from enrollment, but who provide Medi-Cal Covered Services (e.g., Board Certified Behavior Analysts (BCBAs)).
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.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

For 2020040 Preview Only

Attachment A
COVID-19 Emergency Provisions Addendum

During the COVID-19 emergency declaration, certain aspects of the Medi-Cal requirements for Telehealth Covered Services have been waived or altered, as follows:

DHCS has submitted two requests to CMS regarding Section 1135 waivers. Once CMS has acted on these waivers, additional information shall be provided.

Relative to Telehealth, those requests include increased flexibility for FQHCs and RHCs

- During a public emergency declaration, additional flexibility may be granted to FQHCs and RHCs with regard to telehealth encounters, including waiver of the rules in the Medi-Cal Provider Manual, Part 2—Medical: Telehealth regarding "new" and "established" patients, "face-to-face"/in-person, and "four walls" requirements. For telehealth encounters during a public emergency declaration where these requirements have been waived:
    - For telehealth encounters that meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS Code T1015 (T1015-SE for the PPS wrap claim), plus CPT Codes 99201-99205 for new patients or CPT codes 99211-99215 for existing patients.
    - For telehealth encounters that do not meet the Medi-Cal Provider Manual requirements, except for those identified as waived above, the encounter should be billed using HCPCS code G0071.

For the latest information on the Section 1135 waivers, please consult the DHCS website at:

https://www.dhcs.ca.gov/

For 20200402 BOD Review Only

Policy:	MA.2100
Title:	Telehealth and Other Technology-Enabled Services
Department:	Medical Management
Section:	Population Health Management
CEO Approval:	
Effective Date:	03/01/2020
Revised Date:	Not applicable

Applicable to:
- ☐ Medi-Cal
- ☒ OneCare
- ☒ OneCare Connect
- ☐ PACE
- ☐ Administrative - Internal
- ☐ Administrative – External

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I. PURPOSE

This Policy sets forth the requirements for coverage and reimbursement of Telehealth and other technology-enabled Covered Services rendered to CalOptima OneCare and OneCare Connect Members.

II. POLICY

A. CalOptima Members may receive Telehealth Covered Services if they are present at an Originating Site located in either a Rural Health Professional Shortage Area (HPSA), or in a county outside of a Metropolitan Statistical Area (MSA).

B. Covered Services normally furnished on an in-person basis to Members and included on the Centers for Medicare & Medicaid Services (CMS) List of Services (*e.g.,* encounters for professional consultations, office visits, office psychiatry services, and certain other Physician Fee Schedule Services) may be furnished to CalOptima OneCare and OneCare Connect Members via Telehealth, subject to compliance with other requirements for Telehealth Covered Services as set forth in this Policy and applicable laws, regulations and guidance.

C. For purposes of Covered Services furnished via Telehealth, the Originating Site must be at a location of a type approved by CMS.

D. Telehealth Covered Services Encounter must be provided at a Distant Site by Qualified Providers.

E. Except as otherwise permitted under a public emergency waiver, Interactive Audio and Video telecommunications must be used for Telehealth Covered Services, permitting real-time communication between the Distant Site Qualified Provider and the Member. The Member must be present and participating in the Telehealth visit.

F. A medical professional is not required to be present with the Member at the Originating Site unless the Qualified Provider at the Distant Site determines it is Medically Necessary.

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G. CalOptima and its Health Networks shall permit Qualified Providers to render and be reimbursed for Covered Services through Telehealth when consistent with applicable laws, regulations, CMS guidance and this Policy.

H. CalOptima and its Health Networks shall ensure that Qualified Providers using Telehealth to deliver Covered Services comply with applicable laws, regulations, guidance addressing coverage and reimbursement of Covered Services provided via Telehealth.

I. Other Technology-Enabled Services including Virtual Check-In Services, E-Visits, E-Consults, and Remote Monitoring Services that are commonly furnished remotely using telecommunications technology without the same restrictions that apply to Medicare Telehealth Covered Services may also be furnished and reimbursed if they otherwise meet the Medicare laws and regulations and the requirements set forth in this Policy.

J. In the event of a health-related national emergency, CMS may temporarily waive or otherwise modify Telehealth or Other Technology-Enabled Services requirements. Please see addendum attached to this Policy for information related to health-related national emergency waivers.

III. PROCEDURE

A. Member Consent to Telehealth Modality

1. Members must consent to the provision of virtual Covered Services that are provided via secure electronic communications including, but not limited to, Telehealth, Virtual Check-ins and E-Visits, which consent shall be documented in the Member's medical records.

B. Provision of Covered Services through Telehealth

1. A Qualified Provider may provide Covered Services to an established Member via Telehealth when all of the following criteria are met:

   a. The Member is seen in an Originating Site;

   b. The Originating Site is located in either a Rural Health Professional Shortage Area (HPSA) or in a county outside of a Metropolitan Statistical Area (MSA);

   c. The provider furnishing Telehealth Covered Services at the Distant Site is a Qualified Provider;

   d. The Telehealth Covered Services encounter must be provided through Interactive Audio and Video telecommunication that provides real-time communication between the Member and the Qualified Provider (store and forward is limited to certain demonstration projects). See Section III.C. of this Policy for other Technology-Enabled services that are not considered to be Telehealth, and which may be provided using other modalities; and

   e. The type of Telehealth Covered Services fall within those identified in the CMS List of Services (available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes).

   f. The Qualified Provider must be licensed under the state law of the state in which the Distant Site is located, and the Telehealth Covered Service must be within the Qualified Provider's scope of practice under that state's law.

2. The Originating Site for Telehealth Covered Services may be any of the following:

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a. The office of a physician or practitioner;

b. A hospital (inpatient or outpatient);

c. A critical access hospital (CAH);

d. A rural health clinic (RHC);

e. A Federally Qualified Health Center (FQHC);

f. A hospital-based or critical access hospital-based renal dialysis center (including satellites) (independent renal dialysis facilities are not eligible originating sites);

g. A skilled nursing facility (SNF); or

h. A community mental health center (CMHC).

3. Telehealth Service Requirements and Electronic Security

   a. Qualified Providers must use an Interactive Audio and Video telecommunications system that permits real-time communication between the Qualified Provider at the Distant Site and the Member at the Originating Site.

      i. The audio-video Telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through Telehealth.

      ii. The telecommunications equipment must be of a quality or resolution to adequately complete all necessary components to document the level of service for the CPT code or HCPCS code billed.

      iii. Qualified Providers must also comply with the requirements outlined in Section III.D. of this Policy.

4. CalOptima or a Health Network shall authorize Covered Services provided through Telehealth as follows:

   a. For a CalOptima Direct Member, a Qualified Provider shall submit a routine Prior Authorization Request (ARF) based on Medical Necessity for services that would require prior authorization if provided in an in-person encounter, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

   b. For a Health Network Member, a Qualified Provider shall obtain authorization from the Member's Health Network, in accordance with the Health Network's authorization policies and procedures.

5. Medicare Telehealth Covered Services are generally billed as if the service had been furnished in-person. For Medicare Telehealth Services, the claim should reflect the designated Place of Service (POS) code 02-Telehealth, to indicate the billed service was furnished as a professional Telehealth Covered Service from a distant site. Qualified Providers must use the appropriate code for the professional service along with the Telehealth modifier GT ("via Interactive Audio and Video telecommunications systems")

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C. Other Technology-Enabled Services

1. Virtual Check-In Services

a. A Qualified Provider may use brief (5-10 minute), non-face-to-face, Virtual Check-In Services to connect with Members outside of the Qualified Provider's office if all of the following criteria are met:

i. The Virtual Check-In Services are initiated by the Member;

ii. The Member has an established relationship with the Qualified Provider where the communication is not related to a medical visit within the previous seven (7) days and does not lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available);

iii. The provider furnishing the Virtual Check-In Services is a Qualified Provider;

iv. The Member initiates the Virtual Check-In Services (Qualified Providers may educate Members on the availability of the service prior to the Member's consent to such services); and

v. The Member verbally consents to Virtual Check-In Services and the verbal consent is documented in the medical record prior to the Member using such services.

b. Live interactive audio, video or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D below.

c. Qualified Providers may bill for Virtual Check-In Services furnished through secured communication technology modalities, such as telephone (HCPCS code G2012) or captured video or image (HCPCS code G2010).

2. E-Visits

a. Qualified Providers may provide non-face-to-face E-Visit services to a Member through a secure online patient portal if all of the following criteria are met:

i. The Member has an established relationship with a Qualified Provider;

ii. The provider furnishing the E-Visit is a Qualified Provider; and

iii. The Members generates the initial inquiry (communications can occur over a seven (7)-day period).

b. Live interactive audio, video, or data telecommunications, Asynchronous Store and Forward, and telephone may be used for Virtual Check-In Services subject to compliance with Section III.D. of this Policy.

c. Qualified Providers shall use CPT codes 99421-99423 and HCPCS codes G2061-G2063, as applicable, for E-Visits.

3. E-Consults

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a. Inter-professional consults (Qualified Provider to Qualified Provider) using telephone, internet and Electronic Health Record modalities are permitted where such consult services meet the requirements in applicable billing codes, including time requirements.

b. Qualified Providers shall use CPT Codes 99446, 99447, 99448, 99449, 99451, and 99452 for E-Consults.

4. Remote Monitoring Services

a. Remote Monitoring Services are not considered Telehealth Covered Services and include Care Management, Complex Chronic Care Management, Remote Physiologic Monitoring and Principle Care Management services.

b. Remote Monitoring Services must meet the requirements established in applicable billing codes.

D. The Qualified Provider must comply with all applicable laws and regulations governing the security and confidentiality of the electronic transmission. Qualified Providers may not use popular applications that allow for video chats (including Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype) when they are not HIPAA compliant except where state and federal agencies have otherwise permitted such use (e.g., public emergency declarations) and when so permitted, they may only be used for the time period such applications are allowed. In such public emergency circumstances, Qualified Providers are encouraged to notify Members that these third-party applications potentially introduce privacy risks. Qualified Providers should also enable all available encryption and privacy modes when using such applications. Under no circumstances, are public facing applications (such as Facebook Live, Twitch, TikTok, and similar video communication applications) permissible for Telehealth.

E. A Member shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies CMC.9002: Member Grievance Process, CMC.9003: Standard Appeal, CMC.9004: Expedited Appeal, MA.9002: Member Grievance Process, MA.9003: Standard Service Appeal, and MA.9004: Expedited Service Appeal.

F. CalOptima shall process and pay claims for Covered Services provided through Telehealth in accordance with CalOptima Policy MA.3101: Claims Processing. Payments for services covered by this Policy shall be made in accordance with all applicable CMS requirements and guidance.

IV. ATTACHMENT(S)

A. COVID-19 Emergency Provisions Addendum

V. REFERENCE(S)

A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
B. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
C. CalOptima Contract for Health Care Services
D. CalOptima Policy CMC.9002: Member Grievance Process
E. CalOptima Policy CMC.9003: Standard Appeal
F. CalOptima Policy CMC.9004: Expedited Appeal
G. CalOptima Policy MA.9002: Member Grievance Process
H. CalOptima Policy MA.9003: Standard Service Appeal

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I. CalOptima Policy MA.9004: Expedited Service Appeal
J. Title 42 United States Code § 1395m(m)
K. Title 42 CFR §§ 410.78 and 414.65
L. Medicare Claims Processing Manual, Chapter 12 - Physicians/Nonphysician Practitioners, Section 190 – Medicare Payment for Telehealth Services

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency

VII. BOARD ACTION(S)

Date	Meeting
04/02/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	03/01/2020	MA.2100	Telehealth and Other Technology-Enabled Services	OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Asynchronous Store and Forward	The transmission of a Member's medical information from an Originating Site to the health care provider at a Distant Site without the presence of the Member.
CMS List of Services	CMS' list of services identified by HCPCS codes that may be furnished via Telehealth, as modified by CMS from time to time. The CMS List of Services is currently located at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.
Covered Services	OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Centers of Medicare & Medicaid Services (CMS) Contract. OneCare Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way Agreement with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) Contract.
Distant Site	A site where a health care provider who provides health care services is located while providing these services via a telecommunications system. The distant site for purposes of telehealth can be different from the administrative location.
Electronic Consultations (E-consults)	Asynchronous health record consultation services that provide an assessment and management service in which the Member's treating health care practitioner (attending or primary) requests the opinion and/or treatment advice of another health care practitioner (consultant) with specific specialty expertise to assist in the diagnosis and/or management of the Member's health care needs without Member face-to-face contact with the consultant. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions and recommendations of care. E-consults are permissible only between health care providers and fall under the auspice of store and forward.
Federally Qualified Health Centers (FQHC)	A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. An FQHC must be a public entity or a private non-profit organization. FQHCs must provide primary care services for all age groups.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide covered services to Members assigned to that health network.
Interactive Audio and Video	Telecommunications system that permits real-time communication between beneficiary and distant site provider.
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.

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Term	Definition
Medical Record	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.
Member	An enrollee-beneficiary of a CalOptima program.
Metropolitan Statistical Area (MSA)	Areas delineated by the U.S. Office of Management and Budget as having at least one urbanized area with a minimum population of 50,000. A region that consists of a city and surrounding communities that are linked by social and economic factors.
Originating Site	A site where a Member is located at the time health care services are provided via a telecommunications system or where the Asynchronous Store and Forward service originates.
Qualified Provider	Eligible Distant Site practitioners who are: a physician, Nurse Practitioner, Physician Assistant, Nurse-midwife, Clinical Nurse Specialist, Clinical Psychologist, Clinical Social Worker, Registered Dietician or Nutrition Professional, or Certified Registered Nurse Anesthetist. However, neither a Clinical Psychologist nor a Clinical Social Worker may bill for medical evaluation and management services (CPT Codes 90805, 90807, or 90809).
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.
Rural Health Professional Shortage Area (HPSA)	Designations that indicate health care provider shortages in primary care, dental health; or mental health.
Synchronous Interaction	A real-time interaction between a Member and a health care provider located at a Distant Site.
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the Originating Site, and the health care provider is at a Distant Site. Telehealth facilitates Member self-management and caregiver support for Members and includes Synchronous Interactions and Asynchronous Store and Forward transfers.

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

RICHARD FIGUEROA
ACTING DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: October 16, 2019

ALL PLAN LETTER 19-009 (REVISED)

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: TELEHEALTH SERVICES POLICY

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide clarification to Medi-Cal managed care health plans (MCPs) on the Department of Health Care Services' (DHCS) policy on Medi-Cal services offered through a telehealth modality as outlined in the Medi-Cal Provider Manual.[1] This includes clarification on the services that are covered and the expectations related to documentation for the telehealth modality.[2] *Revised text is found in italics.*

BACKGROUND:
The California Telehealth Advancement Act of 2011, as described in Assembly Bill (AB) 415 (Logue, Chapter 547, Statutes of 2011),[3] codified requirements and definitions for the provision of telehealth services in Business and Professions Code (BPC) Section 2290.5,[4] Health and Safety Code (HSC) Section 1374.13,[5] and Welfare and Institutions Code (WIC) Sections 14132.72[6] and 14132.725.[7] For definitions of the terms used in this APL, see the "Medicine: Telehealth" section of the Medi-Cal Provider Manual. Additional information and announcements regarding telehealth are available on the "Telehealth" web page of DHCS' website.

BPC Section 2290.5 requires: 1) documentation of either verbal or written consent for the use of telehealth from the patient; 2) compliance with all state and federal laws regarding the confidentiality of health care information; 3) that a patient's rights to the

[1] The "Medicine: Telehealth" section of the Medi-Cal Provider Manual is available at: https://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part2/mednetele_m01o03.doc
[2] More information on this policy clarification can be found on the "Telehealth" web page of the DHCS website, available at: https://www.dhcs.ca.gov/provgovpart/pages/telehealth.aspx
[3] AB 415 is available at: http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120AB415
[4] BPC Section 2290.5 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=2290.5.&lawCode=BPC
[5] HSC Section 1374.13 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.13.&lawCode=HSC
[6] WIC Section 14132.72 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.72.&lawCode=WIC
[7] WIC Section 14132.725 is available at: http://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=14132.725.&lawCode=WIC

patient's own medical information apply to telehealth interactions; and 4) that the patient not be precluded from receiving in-person health care services after agreeing to receive telehealth services. HSC Section 1374.13 states there is no limitation on the type of setting between a health care provider and a patient when providing covered services appropriately through a telehealth modality.

POLICY:
Each telehealth provider must be licensed in the State of California and enrolled as a Medi-Cal rendering provider or non-physician medical practitioner (NMP). If the provider is not located in California, they must be affiliated with a Medi-Cal enrolled provider group in California (or a border community) as outlined in the Medi-Cal Provider Manual. Each telehealth provider providing Medi-Cal covered services to an MCP member via a telehealth modality must meet the requirements of BPC Section 2290.5(a)(3), or equivalent requirements under California law in which the provider is considered to be licensed, such as providers who are certified by the Behavior Analyst Certification Board, which is accredited by the National Commission on Certifying Agencies. *Providers who do not have a path to enroll in fee-for-service Medi-Cal do not need to enroll with DHCS in order to provide services via telehealth. For example, behavioral analysts do not need to enroll in Medi-Cal to provide services via telehealth.*

Existing Medi-Cal covered services, identified by Current Procedural Terminology – 4th Revision (CPT-4) or Healthcare Common Procedure Coding System (HCPCS) codes and subject to any existing treatment authorization requirements, may be provided via a telehealth modality if all of the following criteria are satisfied:

- The treating health care provider at the distant site believes the services being provided are clinically appropriate to be delivered via telehealth based upon evidence-based medicine and/or best clinical judgment;
- The member has provided verbal or written consent;
- The medical record documentation substantiates the services delivered via telehealth meet the procedural definition and components of the CPT-4 or HCPCS code(s) associated with the covered service; and
- The services provided via telehealth meet all laws regarding confidentiality of health care information and a patient's right to the patient's own medical information.

Certain types of services cannot be appropriately delivered via telehealth. These include services that would otherwise require the in-person presence of the patient for any reason, such as services performed in an operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion/removal of medical devices. A

provider must assess the appropriateness of the telehealth modality to the patient's level of acuity at the time of the service. A health care provider is not required to be present with the patient at the originating site unless determined medically necessary by the provider at the distant site.

MCP providers must use the modifiers defined in the Medi-Cal Provider Manual with the appropriate CPT-4 or HCPCS codes when coding for services delivered via telehealth, for both synchronous interactions and asynchronous store and forward telecommunications. Consultations via asynchronous electronic transmission cannot be initiated directly by patients. Electronic consultations (e-consults) are permissible using CPT-4 code 99451, modifier(s), and medical record documentation as defined in the Medi-Cal Provider Manual. E-consults are permissible only between health care providers. Telehealth may be used for purposes of network adequacy as outlined in APL 19-002: Network Certification Requirements, or any future iterations of this APL, as well as any applicable DHCS guidance.[8]

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 Policy Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

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

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

[8] APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx

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

BRADLEY P. GILBERT, MD, MPP
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: March 18, 2020

SUPPLEMENT TO ALL PLAN LETTER 19-009

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: EMERGENCY TELEHEALTH GUIDANCE - COVID-19 PANDEMIC

PURPOSE:
In response to the COVID-19 pandemic, it is imperative that members practice "social distancing." However, members also need to be able to continue to have access to necessary medical care. Accordingly, Medi-Cal managed care health plans (MCPs) must take steps to allow members to obtain health care via telehealth when medically appropriate to do so as provided in this supplemental guidance.

REQUIREMENTS:
Pursuant to the authority granted in the California Emergency Services Act, all MCPs must, effective immediately, comply with the following:[1]

- Unless otherwise agreed to by the MCP and provider, MCPs must reimburse providers at the same rate, whether a service is provided in-person or through telehealth, if the service is the same regardless of the modality of delivery, as determined by the provider's description of the service on the claim. For example, if an MCP reimburses a provider $100 for an in-person visit, the MCP must reimburse the provider $100 for an equivalent visit done via telehealth unless otherwise agreed to by the MCP and provider.
- MCPs must provide the same amount of reimbursement for a service rendered via telephone as they would if the service is rendered via video, provided the modality by which the service is rendered (telephone versus video) is medically appropriate for the member.

MCPs are responsible for ensuring that their subcontractors and network providers comply with the requirements in this supplemental guidance as well as all applicable state and federal laws and regulations, contract requirements, and other Department of Health Care Services' guidance. MCPs must communicate these requirements to all network providers and subcontractors.

This supplemental guidance will remain in effect until further notice.

[1] Government Code section 8550, et seq.

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

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

SAJID A. AHMED

[*e*] sajcookie@gmail.com [*c*] +1.415.377.9514 [*a*] 1300 Prospect Drive, Redlands, CA

EXECUTIVE PROFILE

Executive with over 25 years of healthcare experience with over three decades of a health information technology leader, ten years leadership experience in healthcare operations, innovation, telehealth, health information exchanges and electronic health record systems, 15 years as a board member for non-profits, and over two decades years as a consultant on transformation and innovation, and as lecturer and speaker

AREAS OF EXPERTISE

Health Information Technology | Telehealth | Virtual Care | Artificial Inteligence (Fuzzy Logic) | Health Information Management System | Healthcare Innovation | Health Information Exchange | Electronic Health Records Systems | Enterprise System Design | Executive Management Experience | Product Development | Interaction Design Strategy | User Interaction Architect | Data Architecture | Healthcare Informatics | Business Development | Strategic Planning |Go-to-market and Adoption Strategies| Board Management |Leadership | Mentoring | Team building

EXECUTIVE SUMMARY

I have over 25 years' experience in health information technology, and over 20 years in executive leadership positions from Executive Director, Chief Technology Officer, Chief Information and Innovation Officers positions, managing healthcare technology companies and delivering technology solutions to healthcare providers and healthcare consumers. I have expertise in business needs assessment; information architecture and usability; technical experience in human/computer Interaction; information structure and access; digital asset and content management; systems analysis and design; data modeling; database architecture and design.

SELECTED KEY ACCOMPLISHMENTS

- Achieved 2017 MostWired Award for Martin Luther King, Jr. Hospital (MLKCH).
- Achieved 2017 HIMSS Level 7 Award (less than 12% of all U.S. Hospitals Achieve)
- Over a year and a half, collaborated with California Health and Human Service, Department of Managed Care Services, CMS Region 9 and CMS in Baltimore to create an exception allowing brand new hospital organizations, like MLKCH, to participate in the Meaningful Use program, resulting in a $5.2 million award for MLKCH.
- I helped launch a brand-new hospital organization and new facilities from the ground up, meaning: new startup healthcare company, new employees, new buildings, new technology new policies and new models of healthcare. I managed $150 million Health IT and IT infrastructure budget, successfully launching a brand-new community-based hospital of the future in South Los Angeles on July 7, 2015, on time and budget. The CEO hired me as employee number 2 of a startup hospital, and healthcare company put together by the State of California, the University of California system and County of Los Angeles.
- Developed the $38.8M State of California Health Information Strategic Plan for Health Information Exchange – Currently serving on the Advisory Board for the U.C. Davis, Institute for Population Management (IPHI) and its California Health eQuality (CHeQ)

Initiative, contracted to provide access to health information exchange and statewide registries to providers and consumers

- Successfully created and launched eConsult – a telehealth and healthcare business process as an innovative new process standard and technology to enable virtual care and provide more efficient specialty care appointments. The eConsult program has successfully launched to over 67 medical facilities and with over 2500 providers in 2012. This initiative expanded to the entire county of Los Angeles in 2013 with over 300 sites and over 5,000 providers using eConsult, becoming a model for a new national standard for referrals and consults. Overall Budget and costs managed $15M.
- Successfully awarded (now) over $18M in federal funding to form the regional extension center for EHR adoption in Los Angeles County. Created, developed and lead all aspects of the formation of the REC, named HITEC-LA.
- Created and lectured HS 430, eHealth Innovations for Healthcare as associate professor at UCLA School of Public Health
- Successfully lead the development and deployment of consumer web portals to Fortune 500 self-insured companies with 10K employees or more portfolio example of User-Interface design and Unix-based SQL database development.
- Invented a new decision-support algorithm for use in healthcare and the US Army (implemented in IRAQ 2003/2004) patient record data mining and other business processes.
- Patented: "System and Method for Decision-Making": Patents ID #60/175,106, and "Determining tiered Outcomes using Bias Values #20020107824
- Successfully, deployed in Germany, Italy and Fort Bragg, North Carolina, Tri-Care based Healthcare record keeping and medical decision support system AD-Doc™.
- Successfully designed, built and helped deploy a Nursing Decision Support system for Kaiser (KP-On Call Inc.).
- Successfully negotiated a multi-million multiyear contract ($128.9M over three years), deployed and customized Electronic Health Record (EHR) Patient record keeping system called CHCS 2.0 with the European Medical Command, United States Army.
- Worked at JPL (Jet Propulsion Labs, NASA) on the Galileo project using Dbase to manage all error tracking for software and hardware.
- Recruited former U.S. Secretary of Health & Human Services (2001) Tommy Thompson to Board of Directors along with other industry leaders

SELECTED BOARDS & COMMITTEES

- 2016 to present – Co-Chair/Advisory Committee on California's Provider Directory Initiative; Co-Chair, Workgroup on Technical and Business Requirements
- 2012 to 2015 – Advisory Board Member of the California Health eQuality Initiative under U.C. Davis to advise on the use $38.8M in federal funds for the state population management and health information exchange.
- 2008 to 2014 - Vice Chair of Technical Advisory Committee (TAC) for L.A. Care reporting its Board of Governors; Advise and review innovations in healthcare technology and operations
- 2010 to Present - UCLA Health Forum Advisory Board; Development forums with eight events recruiting leading healthcare industry executives to speak at UCLA and the community
- 2009 to 2013 – Vice Chair of the Los Angeles Network for Enhanced Services (LANES), a health information exchange organization representing L.A. County Department of Health Services and other stakeholders;

- 2009 to 2010- Co-Chair of the California State Regional Extension Center Committee for the development of RECs and projects totaling over $120M throughout the state
- 2010 to Present – Board Member for the Office of National Coordinator on EHR and Functional Interoperability Committee; Developing standards for data exchange and interoperability standards.
- 2011 to Present – Redlands YMCA Board Member

SELECTED PRESENTATIONS AND LECTURES (UPDATED 2018)

How Artificial Intelligence Will Revolutionize Healthcare
https://itunes.apple.com/us/podcast/himss-socal-podcast/id1314101896.
HIMSS March 15th, 2018

Keynote: Innovation through Disruption – How AI will transform Healthcare
ITC Summit, Chennai, India, March 27th, 2017

Keynote: It's Not Always About the Technology, Effective Coordinated Care Strategies for Better Outcomes;
HIMSS17 Summit, Feb 21, 2017

Keynote: The Future of the CIO
Health Information Technology Summit- January 2017

Keynote: The Building of Martin Luther King, Jr. Hospital: How to create a State-of-Art hospital
Latin American Hospital Expansion Summit – October 15, 2016

Keynote: HIE is DEAD! Long live HIE!
Idea Exchange in Digital Healthcare Summit, University of California Irvine, Wednesday, July 10, 2013

L.A. Care's Innovative eConsult System for L.A. County Safety Net Providers - LA Health Collaborative Meeting October 27, 2011

eConsult – Enhancing Primary Care Capacity and Access to Specialty Care;
2012 Annual Health Care Symposium

Implementing Electronic Health Records (EHRs): Where the Rubber Meets the Road - June 2, 2011eHealth Policy Presentation

"eHealth Today – Community Impact & Reality" A Presentation of The Edmund G. "Pat" Brown Institute of Public Affairs' Health Policy Outreach Center, California State University, Los Angeles December 12, 2011

(A full portfolio of over 25 lectures, keynotes, and presentations since 2001 are available upon request)

PROFESSIONAL EXPERIENCE

Inland Empire Health Plan (IEHP), Rancho Cucamonga, CA 6/2017-Present
Executive Lead, Virtual Care Programs
Multi-County eConsult Initiative

As the executive lead for IEHP, I am working to expand telehealth (Virtual Care) to both counties for all directly managed members of IEHP, over 550,000 members. This project represents over 350 sites and will reach over 1,500 providers, managing a $9 Million budget.

WISE Healthcare Corporation, Redlands, CA ***8/2017-Present***
Chief Executive Officer
Executive Lead, Inland Empire Health Plan

As CEO of WISE Healthcare, I work to expand the company's three major revenue centers: Innovation Strategy professional services, Artificial Intelligence (AI) products and tools and Workflow Design Engineering implementation services. WISE Healthcare delivers artificial intelligence (AI) strategy and workflow engineering to healthcare organizations looking to improve healthcare delivery. I am focused on the launch of the WISE AI based mobile healthcare tool, that will help accurately diagnose many conditions and provide convenient access to care. Currently expanding the leadership staff and increase hiring. I report to the Board of WISE and have been three years to establish a larger presence in the market place and prepare the company to attract investments from the capital markets; support in depth due diligence of all areas of the WISE portfolio, staff, management and operations.

MLK Jr. Los Angeles Healthcare Corp, Los Angeles, CA ***2/2013-7/2017***
Chief Information & Innovations Officer
Executive Director, MLK Campus Innovations Hub

As Chief Information & Innovations Officer ("CIIO"), I was a member of the Executive Team and leading hospital executive with responsibility for information technology & services. I report directly to the Chief Executive Officer of Martin Luther King Jr. Community Hospital of Los Angeles ("MLKCH") which opened June 2015. As CIIO, I provide the strategic vision and leadership in the development and implementation of information technology initiatives for MLK-LA and its affiliates and acquisitions. I direct the planning and implementation of enterprise IT systems in support of business operations to improve cost effectiveness, service quality, and business development. I am responsible for managing the day-to-day functioning of the hospital as well as planning for future capacity and capabilities. Overall, I am responsible for creating and promoting a hospital information strategy that supports the hospital's strategic business goals. I oversee the execution and implementation of the leading hospital systems, including the integration of medical devices and other equipment that tie into the EMR to facilitate improvements in patient safety and real-time availability of critical information to business operation.

As the Innovations Officer, I bring to light and support new processes and technologies to help improve patient outcomes and improve efficiencies throughout the hospital and

its provider and patient community. With Molly Coye, I helped create the Los Angeles Innovators Forum, bringing together innovation leaders, officers from local diverse provider organizations, Cedars, UCLA, Motion and Television Association, Veterans Affairs, L.A. Care, Molina, WellPoint, and others.

L.A. Care Health Plan, Los Angeles, CA ***9/2008 – 3/2013***
Executive Director, Health Information Technology & Innovation
Executive Director, Safety Net eConsult Program (2010 – 2013)

As Executive Director of Healthcare Information Technology (HIT) and Innovation, I was responsible for the coordination, management and integration of healthcare information technology and health initiatives both internally and externally, in line with the mission and strategic plans of LA Care. My responsibilities included collaboration and strategy development with internal and external health IT stakeholders, trading partners, health IT collaborates, providers, regulatory and government agencies and others. Also, I provided leadership and collaboration in interdepartmental and cross-functional ehealth initiatives. I worked as a liaison between Health Services and Information Services to facilitate and support ehealth initiatives and HIT activities.

Additionally, I was responsible for building relationships with diverse external HIT organizations and facilitating strategies to position LA Care as the leader in HIT adoption and health quality improvement on a local, regional and national level. I have presented in many forums such as the California eRx Consortium as co-chair; Co-chair of the Regional Extension Center Workgroup for California Health and Human Services Agency; and participate as a Board member of Health-e-LA, a HIE for Los Angeles County.

Key highlights below:

- Launched eConsult program connecting primary care physicians to specialists
- Implemented eConsult throughout Los Angeles County and its over 4 million patients, 300 clinic sites and over 5,000 providers. Helped reduce no-show rates of patients by 86% and increased access to appropriate specialty care for underserved.
- Developed a $ 22.3 million sustainable business plan and successfully applied for the Regional Extension Center Program for Los Angeles County, as part stimulus funding opportunity through ARRA and the HITECH Act
- Successful acquired 18.6 million in regional extension center funding for L.A. Care
- Developed L.A. Care's Health Information Technology Strategic Plan 2010-2012 and revised 2013-2015, affecting over $40 Million in HIT incentives, grants, and eHealth projects
- Developed as Co-Chair the State of California's Health Information Technology and Exchange Strategic Plan affecting over $120 Million in projects statewide

Spot Runner, Inc., Los Angeles, CA ***4/2008 – 8/2008***
Sr. Data Architect & Systems Consultant

- Lead a 15-member Data Services Team designing complex database models and the complex media exchange platform for the mid-size start-up
- Responsible for developing strategic plans and hands-on experience with business requirements gathering/analysis

- Worked with Senior Management with regards to scope and schedules of new Media Platforms initiative
- Member of Project and Product Management teams in scoping requirements and planning development in full product life-cycle
- Responsible for all aspects of the data architecture including translating business requirements into conceptual data models, logical design, and physical design
- Participating with the engineering team in all activities including architecture, design, software development, QA, performance benchmarking and optimization, as well as deployment
- Working with Business Systems Analysts (BSA) and other technical areas to determine feasibility, level of effort, timing, scheduling, and other related aspects of project proposals and planning
- Working as part of the core architecture team as well as with the system architect to design the entire system including the web tier, application tier, and database tier
- Demonstrated the ability to prioritize efforts in a rapidly changing environment

Home Box Office (HBO) Inc., Santa Monica, CA ***3/2007- 4/2008***
Consultant, Sr. Data Architect

- Worked to enhance data policies, including security and reporting efficiencies
- Responsibility included hands-on training of senior management and Senior Business Analyst on design standards and DBA practices.
- The major project included scoping and consulting on conversion of over 550 databases to upgrade platform both upgrading database application and upgrading hardware using ETL tools.
- Professionally interacted with all levels of staff at HBO as the conversion affects all levels of HBO business and every departments' workflow
- Aided launch of the new custom site for "This Just In" working with HBO partner AOL integrating with teams. (www.thisjustin.com)
- Lead efforts to training internal and partner end-user clients

SelfMD, Pasadena, CA ***3/2005-3/2007***
Chief Technology Officer

SelfMD was a consumer-centered technology delivered through web-enabled platforms and devices. I led a team of 30 team members in design, scope, engineering and execution for NowMD.com, (AD-Doc) Artificial Diagnostic Doctor and was consulting with the WebMD through acquisition phase. I managed over 60 employees with ten direct reports on two continents as part of national effort to deliver the technology.

- Lead the development of initial technology and programming of the core software engine, Managed Artistic Directors, Web Developers and a staff of over 30 employees
- Developed Enterprise-Level Database Structure and initial User Interface
- Designed and executed testing methodologies for the engine and its accuracy and data normalization
- Established standards for data entry, content management and upgrading and data normalization.
- Scoped entire project for further outsourcing for large Web site management and data warehousing.

- Managed a remote team of 12 people tasked with over 16 months of custom configuration and development with US Army integrating into their electronic medical record keeping system, CHCS 1.0 data warehouses in three major European locations.
- Creating a technical process to identify data issues and a business process to resolve them

IGP Technologies, Inc., Pasadena, CA ***7/1999 –2/2007***
Chief Information Officer, Healthcare Information Architecture

Worked in a Healthcare IT early-stage company to develop and deploy an enterprise level service. Some clients included Texas Instruments, US Army: TATRC, European Medical Command, US Army Medical Command, Aetna, WellPoint, AT&T, Cadbury Schweppes, California Workers Compensation Board, California Healthcare Underwriters, US Women's Chamber of Commerce.

- Professionally interacted industry C-level Officers in open presentations and analysis.
- Created numerous presentations, drafted various government-grade project proposals with budgets over $32M.
- Managed up to 60 staff in project development stage of technology and remotely operated implementation. With an overseas team from India
- Managed project development stage of technology and remotely with implementation.
- Created, managed and supervised yearly project multimillion budgets, creating financial reports.
- Excellent communication skills developed; thorough knowledge of general software and networks.
- Performed advanced analyses, rendering business strategies and product information as detailed product requirement documents
- developed and implemented metadata and hierarchies using various asset/ content management systems
- constructed user interfaces for multifaceted technical software applications
- guided creation of data models/ maps, architectures, wireframes, process, and user flows for large-scale transactional sites in collaboration with designers, technologists, and strategists
- administered technology department: allocated resources, directed technical project managers, organized training, planned moves
- developed process methodology intranet as a senior member of Process Development Team

SELECTED AWARDS AND HONORS

2018 HIMSS LEVEL 7 Hospital Award for Martin Luther King, Jr. Hospital

2017 MostWired Hospital for Martin Luther King, Jr. Hospital

2016 Chief Technology/Information Officer of the Year, LA Business Journal

University of Southern California (USC), Cal State Long Beach, Caltech *2002-Present*
Guest Lecturer/Speaker/Course Instructor Graduate Schools, USC Price School of Public Policy and UCLA's Fielding School of Public Health

Yearly, "Distinguished Speaker Series" for various undergraduate and graduate entrepreneurial and business departments, courses involving design, development, and implementation of software and databases.

ABL Innovative Leadership (Advanced Business League) Award: Finalist for product development (bested only by Kaiser's "Thrive" website)

Awarded California Health and Human Services (CHHS) for meritorious participation in support and development of California's Health IT Strategic Plan and Regional Extension Center Committee

EDUCATION

UCLA, the University of California at Los Angeles, Los Angeles, CA, Psychology; Computer Science course work

Awarded Certificate, "Certified Health Chief Information Officer" (CHCIO), fall 2013, renewed fall 2016 by the Chief Health Information Management Executive (CHIME)

2014 LEAN Healthcare Certificate from Hospital Association of Southern California

UT Dallas, University of Texas, Dallas, Naveen Jindal School of Management, Master's in Healthcare, Healthcare Leadership Management; in progress

BOARD EXPEREINCE

Currently serving on the Board of Directors and advisory boards for three key technology startups (early and mid-stage companies) in healthcare focused on Artificial Intelligence, Pharmaceuticals, Health IT Services.

Tagnos, Inc. 2017 - Present
A member of the board of advisory, providing direction to growth and new global markets.

Electronic Health Networks, Inc.
2017 – Present
A member of the board of directors, providing direction to growth and new global markets.

California Provider Directory Advisory Board
2016 – Present
A member of the Advisory Board to establish a single state-wide provider directory. Currently co-chair of the Workgroup on data definitions and technical requirements for a state-wide request for proposals.

Advisory Board Member of SNC. Inc.
2012 – Present
Serving as an Advisory Board member of a private commercial, leading care coordination, telehealth technology company.

Board Member of the East Valley Family YMCA
2011 – Present
On an active board of a three facility YMCA representing the cities of San Bernardino, Highland, Redlands. Participating in the Program and Development subcommittees.

Founding Board Member of LANES, the Los Angeles Network for Enhanced Services 2009 – 2013
Active board member, Co-Chair with the deputy CEO of Los Angeles County to establish a county-wide health information exchange. Procured over $2.1 million dollars as board member for LANES. Left Board to join Martin Luther King, Jr. Hospital as Chief Information and Innovation Officer in 2013.

Chair, L.A. Care Technical Advisory Board
2008 – 2013
A brown-act managed advisory board, legislatively required advisory board for the local initiative health plan of Los Angeles County (dba L.A. Care).

Board Member of Health-e-LA
2008 - 2012
A local health information exchange, established to serve county and L.A. Care. Facilitated the close of organization.

PETER J. SCHEID, M.D.

EXPERIENCE

8/8/14-Present Peter J. Scheid, M.D., Inc. Capistrano Beach, CA

Addiction Medicine Physician

- Comprehensive admission evaluation
- Medical detoxification
- Medication Assisted Treatment
- Ongoing medical support
- Recovery counseling

1/14/13-5/31/13 East Valley Community Health Center W. Covina, CA

Per Diem Physician

- Direct patient care
- Oversight of Nurse Practitioner

11/1/10-5/30/13 CalOptima Orange, CA

Medical Director, Clinical Operations

- Oversight of Utilization Management Medical Directors
- Utilization Managmement
- Quality Management
- Management of Health Network relationships
- Grievance and Appeals oversight

1/1/08-10/31/10 CalOptima Orange, CA

Medical Director, Utilization Management

- Management of 370,000 Medi-Cal members
- Utilization Management
- Oversight of Concurrent Review and Prior Authorization activities

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3/07-1/08 Primary Provider Management Company San Diego, CA
Medical Director, Family Choice Medical Group, Vantage Medical Group-San Diego

- Management of over 50,000 members
- Utilization Management
- Quality Management
- Case Management
- Oversight of Hospitalist Program

1/06-2/07 County of Orange Health Care Agency Santa Ana, CA
Physician Consultant, Medical Services for Indigents Program

- Utilization Management
- Program Development
- Formulary Development

10/02–7/07 Community Care Health Centers Huntington Beach, CA
Associate Medical Director

- Wrote application securing FQHC Look-Alike status for all sites
- Medical Director of Clinic for Women and El Modena Health Centers
- Oversight of Quality Management Program
- Developed specialty clinics for patients with chronic disease
- Management of clinical staff including recruitment, retention, and performance monitoring

08/01-9/02 University of California, San Diego San Diego, CA
Clinical Instructor of Family Medicine, Department of Family and Preventive Medicine

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EDUCATION

7/2013-6/2014 Addiction Medicine Fellowship — Loma Linda, CA
Loma Linda University Medical Center

12/2006-9/2008 Health Care Leadership Program — San Francisco, CA
Fellow of Program Sponsored by California Health Care Foundation

7/2000-6/2001 Chief Resident — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1998-6/2001 Family Medicine Residency — San Diego, CA
UCSD Department of Family & Preventive Medicine

7/1994-6/1998 Medical School — Detroit, MI
Wayne State University School of Medicine

- Alpha Omega Alpha Medical Honor Society

9/1987-6/1990 Bachelor of Arts in English — East Lansing, MI
Michigan State University

LICENSURE & CERTIFICATION

2001-Present	California A070698
2001-Present	Diplomate, American Board of Family Practice
2014-Present	Diplomate, American Board of Addiction Medicine
2020-Present	Diplomate, American Board of Preventive Medicine, Addiction Medicine

PROFESSIONAL ASSOCIATIONS

American Academy of Family Physicians

American Society of Addiction Medicine

California Society of Addiction Medicine

REFERENCES AVAILABLE ON REQUEST

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TANYA DANSKY, MD

PROFESSIONAL SUMMARY

Highly trained healthcare executive with 10+ years of clinical background and 10+ years of managed care leadership successful at leveraging career experience to enhance organizational productivity and efficiency by supporting healthcare from the payer and provider perspective.

Dedicated clinician with diverse experiences able to excel within complex systems due to my collaborative, patient centered, results oriented approach to challenges.

SKILLS/EXPERTISE

Executive Leadership
Medi-Cal and CA Commercial HMO
Quality Improvement
Utilization Management
Strategic Business Operations
Value Based Contracting
Washington State Medicaid
Population Health
Innovation
Social Determinants of Health

WORK HISTORY

Independent Consulting Feb. 2020 – Present

Clinical Advisor, Harbage Consulting

- Projects include providing clinical leadership and expertise for:
  - the ACES Aware project (Department of Health Care Services, Medi-Cal and Office of the Surgeon General, State of California)
  - CalAIM Enhanced Case Management and In Lieu of Services

Blue Shield of California April 2017 – Feb. 2020

VP & Chief Medical Officer, Promise Health Plan

- Direct report to Chief Health Officer with responsibility for all aspects of medical management including Utilization Management, Case Management, Social Services and Programs, Quality, Grievances and Appeals
- Medicaid managed care plan with 350,000 covered lives
- Clinical leadership during transition from Care1st Health Plan including full integration of 500+ employees, IT systems and process transformation during 2018 and 2019
- Launched Promise as first California Medi-Cal health plan to join Integrated Healthcare Association's Align Measure Perform program
- Led innovation partnerships to improve quality and access for the safety net including eConsult, a bilingual pregnancy app and a multicultural texting solution

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- Experience implementing value based contracts for the Health Homes Program
- Clinical leadership for Blue Sky program: awareness, advocacy and access for youth mental health and resilience
- Success in quickly building external leadership presence at local, county and statewide levels including San Diego 211 Community Information Exchange Advisory Board and the ACES Aware Advisory Committee for the Office of the Surgeon General and DHCS

Amerigroup Washington (Anthem); Seattle, WA November 2015 – March 2017

Chief Medical Officer

- Direct report to Plan President with responsibility for all aspects of medical management including Utilization Management, Case Management, Quality, Customer Service, and Grievances and Appeals
- Success working in highly matrixed corporate environment with local state plan responsibility
- Medicaid managed care plan with 150,000 covered lives including TANF, Adult expansion and SSI populations throughout 36 counties in Washington State.
- Currently implementing Summit care coordination program for highest risk, highest utilizers leveraging relationships with key providers and community partners to address social determinants of health

Columbia United Providers; Vancouver, WA May 2014 – November 2015

Chief Medical Officer & Vice President

- Played essential role in CUP leadership team's remarkable 2014 accomplishments including securing direct Medicaid Contract with WA State HealthCare Authority, establishing first time commercial products for WA Health Benefit Exchange, and achieving 100% on initial NCQA Certification
- Strengthened relationships and negotiated contracts with key network providers to allow access to high quality care for 50,000+ Medicaid members
- Brought positive leadership and business acumen to an established company actively in transition due to healthcare reform pressures
- Revitalized and established the quality, compliance, network development, marketing, social media and health management departments during first 12 months at CUP

Chief Physicians Medical Group; San Diego, CA January 2006 – May 2014

Chief Executive Officer (10/11-5/14)
Medical Director (7/06-5/14)
Inpatient Medical Director (1/06-7/06)

- Responsible for year over year financial and performance success of $50M pediatric IPA co-owned by pediatric primary care and specialist groups representing 400+ physicians.
- Negotiated and managed contracts with 7 health plans for Commercial HMO and Medi-Cal lines of business comprising over 75,000 pediatric managed care lives.
- Experienced medical director with direct responsibility for utilization management, case management, quality, and credentialing.
- Played key role in formation of clinically integrated network comprised of IPA, hospital and physician group, Rady Children's Health Network.
- Provided leadership and key operational expertise during acquisition of MSO services for 125,000 managed care Medi-Cal lives for CHOC Health Alliance (Children's Hospital of Orange County).
- Served in interim role as Chief Medical Officer for CHOC Health Alliance in Orange County which included strategic and operational presentations to CHOC Health Alliance Board comprised of CHOC Hospital executive leadership and CHOC physician groups' executive leadership teams.

EDUCATION

California Healthcare Foundation Leadership Program
Fellow, 2010 - 2012

University of California, San Diego
Pediatric Residency and Chief Residency, 1999

University of Southern California School of Medicine (Keck), Los Angeles
MD, 1995

University of California, Davis
BS in Physiology, 1991

CLINICAL EXPERIENCE

Rady Children's Pediatric Hospitalist

Rady Children's Pediatric Urgent Care Provider

San Diego Juvenile Hall Clinic Medical Director

Chadwick Center Child Abuse Consultant

San Diego Hospice Children's Program Medical Director (including Palliative Care)

*Full Curriculum Vitae available upon request for additional awards, research, publications, community experience

A Public Agency

CalOptima

Better. Together.

Virtual Care Strategy: Road Map to Increase Access to Care

Board of Directors Meeting

May 7, 2020

Sajid Ahmed, CEO WISE Healthcare, CalOptima Virtual Care Expert

Betsy Chang Ha, RN, MS, LSSMBB
Executive Director, Quality & Population Health Management

On Strategy

"For some organizations, near-term survival is the only agenda item.

Others are peering through the fog of uncertainty, thinking about how to position themselves once the crisis has passed and things return to normal.

The question is, 'What will normal look like?' While no one can say how long the crisis will last, what we find on the other side will not look like the normal of recent years."

~ Ian Davis, 2009

During the Great Recession

Agenda

- Traditional Barriers to Telehealth
  - Impact of COVID-19 on Regulations
- Virtual Care Definition (Telehealth)
- Virtual Care Modalities
- Virtual Care Roadmap Approach
  - Logic Model: Virtual Care Adoption for CalOptima
- The Future
  - Lifting of Barriers
  - Will They Stay or Will They Go Now?
- CalOptima Virtual Care Strategy

Traditional Barriers

- Payment and compensation (Provided due to COVID-19)
- Disruptive to current workflow (Yes, post COVID-19)
- Got enough on my plate (COVID-19 response is priority)
- Their convenience, not mine (COVID-19 response is priority)
- New technology, learning (Not really but in some cases)
- Laws, rules, and regulations (Relaxed due to COVID-19)
- Liability questions (Telehealth Insurance now standard)

Impact of COVID-19 on Regulations

- On March 11, 2020, the World Health Organization declared the COVID-19 outbreak a pandemic.
- On March 15, Health and Human Services issued a "limited waiver" of Health Insurance Portability and Accountability Act sanctions.
- On March 17, Centers for Medicare & Medicaid Services said it would expand Medicare coverage of telemedicine services.
  - CMS said Medicare will pay providers the same in-person rates for virtual visits with hospitals, doctors and other licensed clinicians […] regardless of the patients' location.
- And on and on ...

Virtual Care Definition

- Beyond telehealth, Virtual Care is a broad definition encompassing any modality of remote technologically driven patient health care delivery, device use, monitoring and treatment.

- A recent paper offered the following definition of virtual care:
  - Any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies, with the aim of facilitating or maximizing the quality and effectiveness of patient care.

By Shaw J, Jamieson T, Agarwal P, et al. Virtual care policy recommendations for patient-centered primary care: findings of a consensus policy dialogue using a nominal group technique. J Telemed Telecare 2018;24(9):608-15.

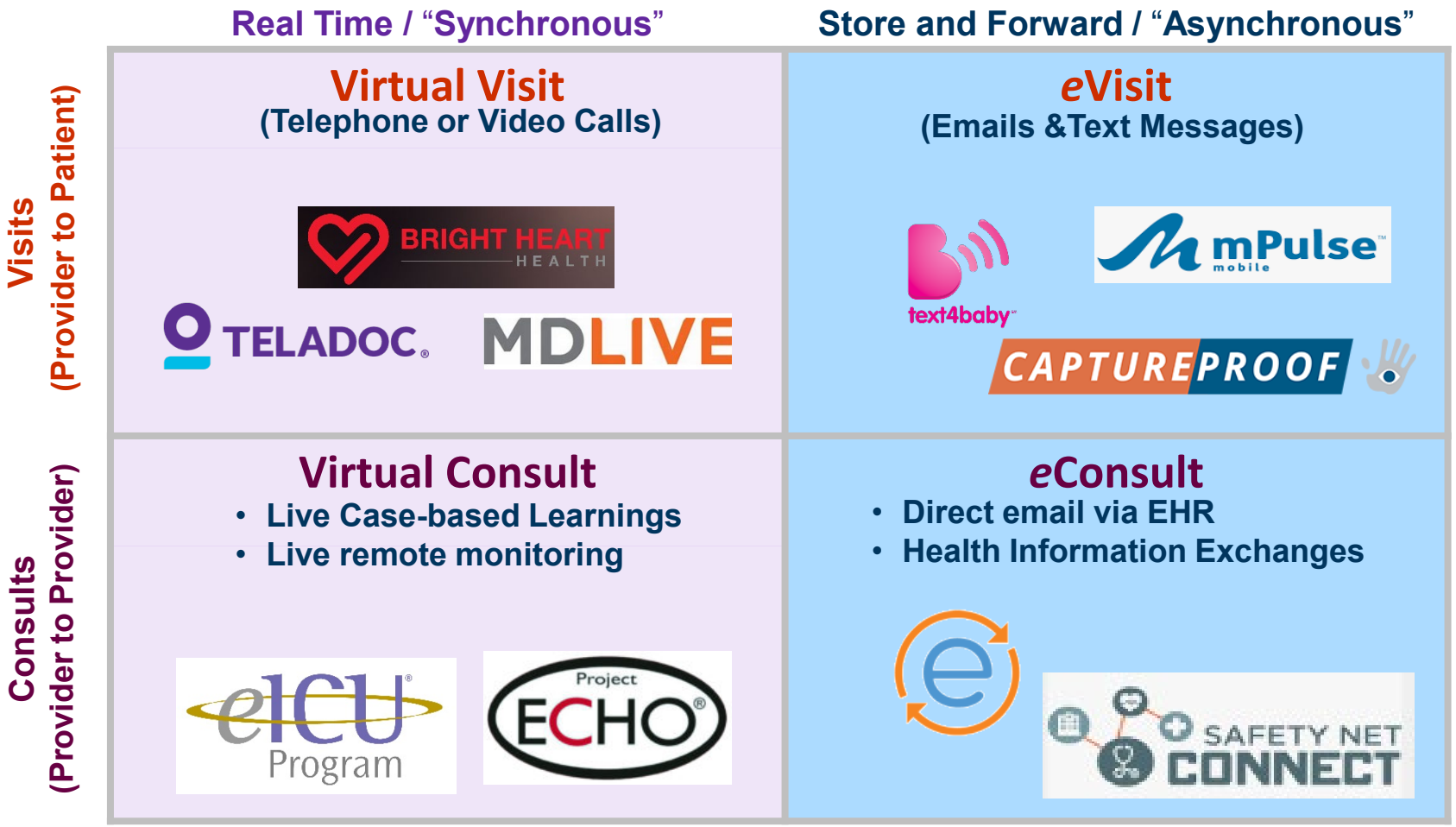
Virtual Care Modalities

	Real Time "Synchronous"	**Store and Forward** "Asynchronous"
Visits (Provider to Patient)	**Virtual Visit**  Video/telephonic visit between provider and patient	***e*Visit**  Online exchange (e.g., email or text) between provider and patient
Consults (Provider to Provider)	**Virtual Consult**  Video/telephonic consult between provider to patient's provider	***e*Consult**  Online consult between specialist to patient's local provider

Virtual Care **IS** care provided via phone, email, text, and video.
87% of all diagnostic decisions can be made via Virtual Care

Image courtesy of Sajid Ahmed at WISE Healthcare.

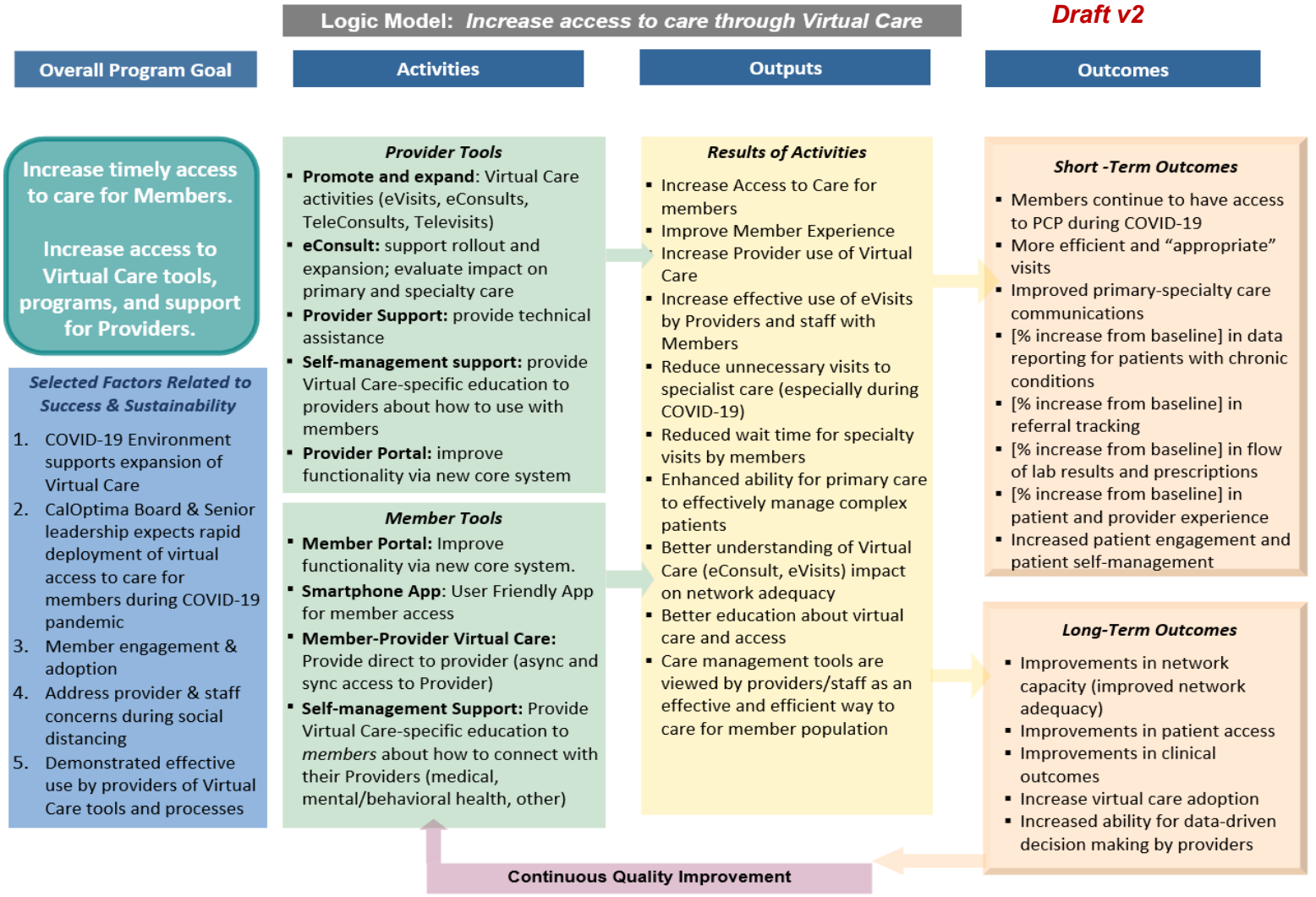
Examples of Virtual Care Modalities



Examples only. CalOptima does not endorse specific vendor.

Image courtesy of Sajid Ahmed at WISE Healthcare.

Logic Model: Increase Access to Care Through Virtual Care



MCP Guidance for Use of Virtual Care by Members and Contracted Providers (cont.)

Member

- Member will use the provider-given cell number to **text** the provider with their reason to request a virtual visit (chief complaint, medical concern, follow-up visit).
- Provider and member will communicate back and forth using text messages (member to provider eConsult).
  - If member concerns are resolved at this stage, no further action is necessary.
- If the provider deems a phone **call** necessary, text messages will be used to coordinate the call.
  - With all stages of communication, the provider can use any location (home) as a responding site.
- If after the phone conversation the provider deems that a **video call** would be necessary, text messages are used to coordinate a video call.

Disclaimer: MCPs do not recommend, endorse, nor sponsor specific messaging applications nor cellular providers.

MCP Guidance for Use of Virtual Care by Members and Contracted Providers

Due to COVID-19, select federal and state virtual care restrictions have been lifted — the use of smartphones and other communication applications to facilitate dialogue between providers and members has been approved. This communication will be allowed and reimbursable per CMS and DHCS directives.

Protocol: Providers and members can text, call and video call to coordinate and manage care to and from any location (home).

Providers

Providers will select a SMS text enabled cell number that can be used by patients. If possible, this can be the provider's primary cell number or:

- An app can be used that allows the provider to receive multimedia messages (WhatsApp, iMessage, Line, GroupMe, Google Duo, Arya, etc.)
- Providers can obtain a new cell number to be used for this purpose through any cellular carrier

Providers can designate a staff member to monitor communication with this number (possibly through a group chat) and facilitate member provider coordination.

Every Cloud Has a Silver Lining...

- It took the COVID-19 pandemic to
  - Waive or relax most health care regulations to ensure that patients get the best possible care at the lowest possible cost, when and where they need it.
- The federal rules and regulations providing limited waivers due to the COVID-19 pandemic are:
  - **HIPAA sanctions waiver** — waiving patient consent
  - **Telemedicine reimbursement** — provided for all virtual care
  - **Physician scope of practice** — lets "all doctors and medical professionals to practice across state lines to meet the needs of hospitals that may arise in adjoining areas"
  - **Elective surgery guidance** — limits elective surgical and dental procedures for adults
  - **Quality reporting requirements** — suspended or extended

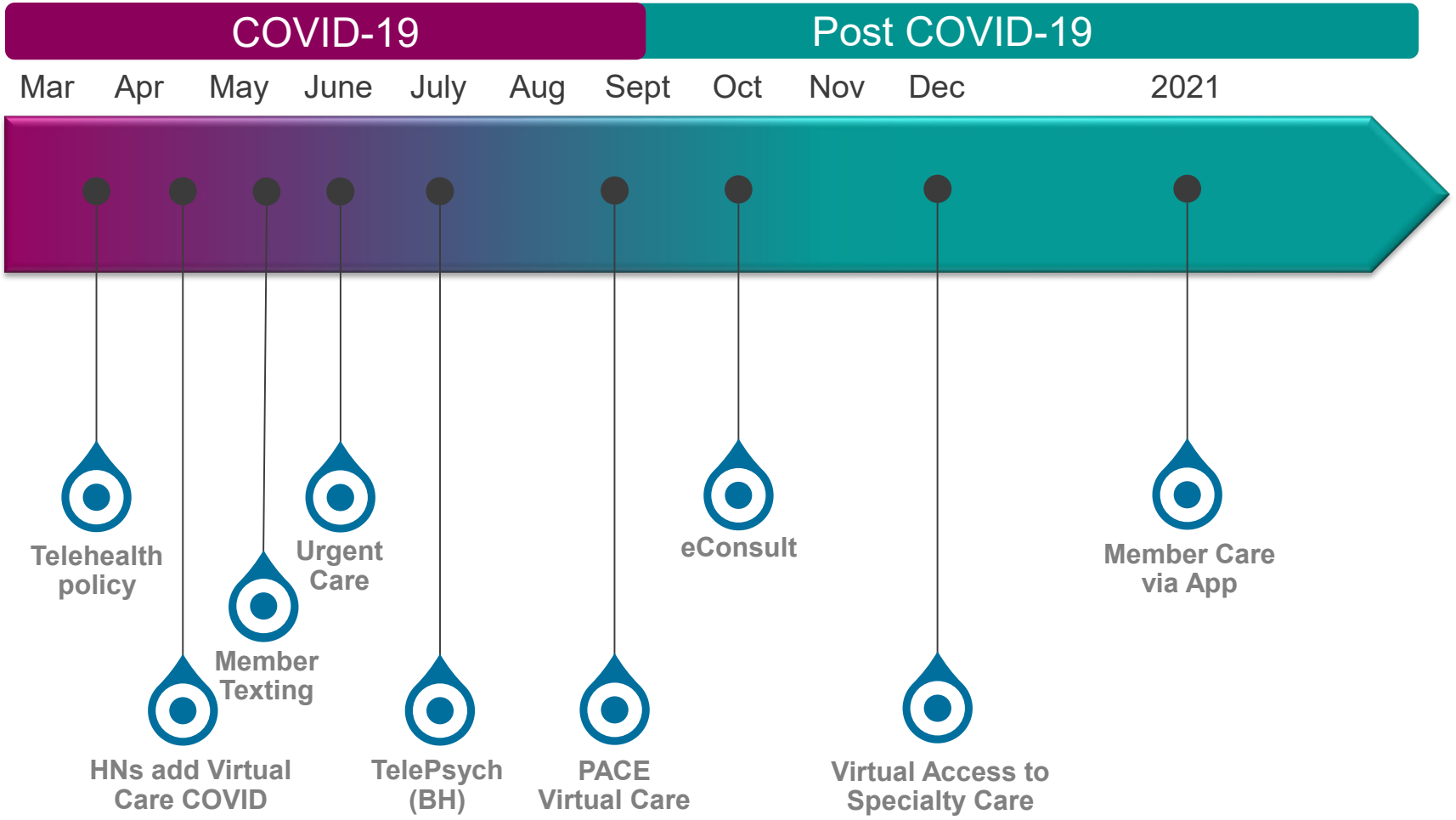
Regulations: Will They Stay, or Will They Go?

- The outbreak shined a light on all the rules and regulations that the U.S. health care system operates under.
- Regulations and rules shown to be impediments to safe, effective, convenient, accessible and affordable care for members.
- CalOptima's long term Virtual Care strategy provides a roadmap to navigate the future in providing low-cost, high quality, timely access to care.

Key Takeaways

- COVID-19 morphed virtual care into a powerful resource that enables the disruption of health care delivery.
- In-person care and virtual care are to be treated the same as appropriate. With virtual care expected to be the primary modality to access care in the future.
  - The “new normal”
- Leadership support is needed from the Board, Chiefs, physician champions, and Health Networks to achieve success and meet the challenges and opportunities of the health care “new normal”

High Level Virtual Care Roadmap



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CalOptima Virtual Care Strategy (Road Map)

Board of Directors Regular Meeting

May 7, 2020

David Ramirez, M.D., Chief Medical Officer

Betsy Chang Ha, RN, MS, LSSMBB

Executive Director, Quality & Population Health Management

Virtual Care Guiding Principles

- Promote the availability and use of virtual modes of service delivery for CalOptima members using information and communications technologies to facilitate diagnosis, consultation, treatment, education, care management and member self-management;
- Leverage existing delivery model where possible;
- To be proactive in seeking out opportunities to innovate; and
- To provide technology-agnostic solutions.

Proposed Initial Virtual Care Strategy: All Members (HN/CCN/COD)

Member to Provider		
Goals	**Use Existing Network Providers**	**Contract Vendor(s) to support limited scope of services during COVID-19**
Tasks	• Leverage existing capabilities • Guidance • Technical support • Technology agnostic	• Member self-referral via Member Portal (web) • Urgent care • Prescription management • Access to Behavioral Health
Time	Q1 2020	Initiate Contract in Q2–Q3 2020
Action	**Update Telehealth Policy (completed)**	**RFP (IGT 9) for vendor(s)**

Proposed Initial Virtual Care Strategy: CalOptima Community Network & CalOptima Direct

	Member to Provider	Provider to Provider
Goals	**Provide Virtual Care:** Member access to Provider Group(s), eVisits to primary care and specialist services	**Implement eConsult (CCN)** (Provider to Provider) per DHCS APL 19-009 to provide eConsult as a covered benefit
Tasks	• Support existing physical primary care providers and specialists • Behavioral Health Services (for all members) • Expand specialty providers with a virtual care focus	• Prior Authorization process modified to allow eConsult to replace authorization • Make available to PACE as well • Provider self-service and submit authorization via Provider Portal and eConsult
Time	Selection in Q3 2020	Contract in Q4 2020
Action	**Evaluate telehealth providers/groups**	**Develop plan to implement eConsult**

Virtual Care Roadmap Q2–Q4

High Level Activities

1. Member engagement approaches, app support and tools
2. Continue activities to support COVID-19 related items
3. Virtual Care technical platform for PACE
   - Facilitate provider-member virtual visits
4. Investigate and implement provider support and technical assistance
5. In progress:
   - Virtual Care Strategy and Roadmap
   - CalOptima Virtual Care Team
6. Expand specialty providers with a virtual care focus
   - Behavioral health and other specialties

Virtual Care Roadmap Q2–Q4 (cont.)

High Level Activities (cont.)

7. Offer 24/7 virtual visits (after-hour access)
   - Acute non-emergency medical conditions
   - Behavioral health conditions
8. Investigate and implement CalOptima member engagement access via member portal app
   - APIs to virtual visits, eVisits, secure messaging
9. Plan and launch eConsult/eReferral program for CCN
10. Member texting
    - E.g. Text For Baby, notifications, alerts via CalOptima Smart app, e.g. IEHP Smart Care app
11. RFP for member direct to provider access
    - Member to provider


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Medi-Cal
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OneCare (HMO SNP)
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OneCare Connect
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PACE
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Logic Model: *Increase access to care through Virtual Care*

Draft v2

Overall Program Goal	Activities	Outputs	Outcomes

Increase timely access to care for Members.

Increase access to Virtual Care tools, programs, and support for Providers.

Selected Factors Related to Success & Sustainability

1. COVID-19 Environment supports expansion of Virtual Care
2. CalOptima Board & Senior leadership expects rapid deployment of virtual access to care for members during COVID-19 pandemic
3. Member engagement & adoption
4. Address provider & staff concerns during social distancing
5. Demonstrated effective use by providers of Virtual Care tools and processes

Provider Tools

- **Promote and expand**: Virtual Care activities (eVisits, eConsults, TeleConsults, Televisits)
- **eConsult:** support rollout and expansion; evaluate impact on primary and specialty care
- **Provider Support:** provide technical assistance
- **Self-management support:** provide Virtual Care-specific education to providers about how to use with members
- **Provider Portal:** improve functionality via new core system

Member Tools

- **Member Portal:** Improve functionality via new core system.
- **Smartphone App**: User Friendly App for member access
- **Member-Provider Virtual Care:** Provide direct to provider (async and sync access to Provider)
- **Self-management Support:** Provide Virtual Care-specific education to *members* about how to connect with their Providers (medical, mental/behavioral health, other)

Results of Activities

- Increase Access to Care for members
- Improve Member Experience
- Increase Provider use of Virtual Care
- Increase effective use of eVisits by Providers and staff with Members
- Reduce unnecessary visits to specialist care (especially during COVID-19)
- Reduced wait time for specialty visits by members
- Enhanced ability for primary care to effectively manage complex patients
- Better understanding of Virtual Care (eConsult, eVisits) impact on network adequacy
- Better education about virtual care and access
- Care management tools are viewed by providers/staff as an effective and efficient way to care for member population

Short -Term Outcomes

- Members continue to have access to PCP during COVID-19
- More efficient and "appropriate" visits
- Improved primary-specialty care communications
- [% increase from baseline] in data reporting for patients with chronic conditions
- [% increase from baseline] in referral tracking
- [% increase from baseline] in flow of lab results and prescriptions
- [% increase from baseline] in patient and provider experience
- Increased patient engagement and patient self-management

Long-Term Outcomes

- Improvements in network capacity (improved network adequacy)
- Improvements in patient access
- Improvements in clinical outcomes
- Increase virtual care adoption
- Increased ability for data-driven decision making by providers

Continuous Quality Improvement

Version 1.1 – 4-06-2020

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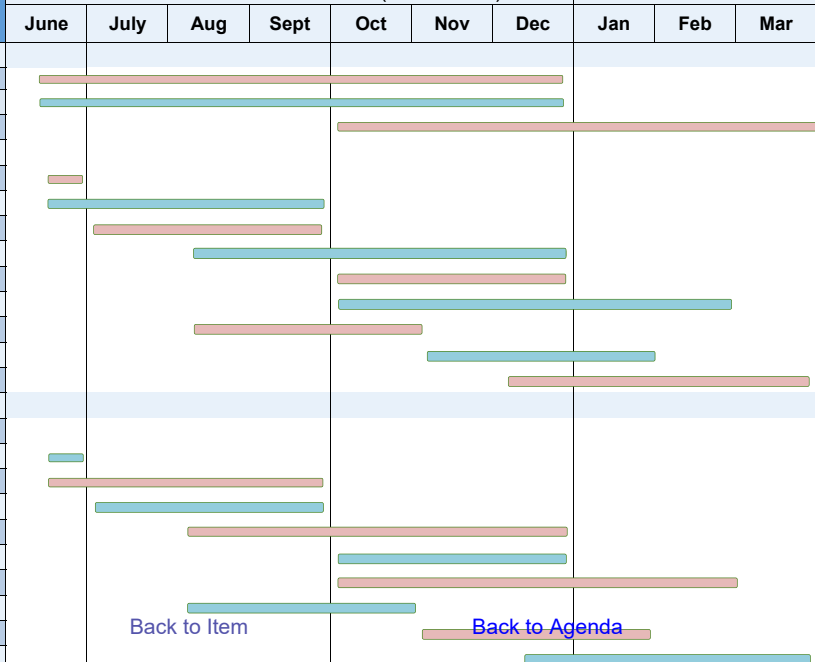
Cal Optima Virtual Care High Level Workplan

2020 - Phase IIA - Foundation (New Fiscal)



TEAM SUMMARY SCORES

RFP 19-020 – Mobile Text Messaging Services

Proposals Scores

Vendor Name	Score
mPulse	3.57
HealthCrowd	3.45
Bluespire	3.63
TigerConnect	3.32
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

Interview Scores

Vendor Name	Score
mPulse	4.30
HealthCrowd	4.18
Bluespire	3.73
TigerConnect	2.51
Medecision	0.00
MTX Group Inc.	0.00
Variedy	0.00
Care3	0.00

Overall Scores

Vendor Name	Score
mPulse	3.94
HealthCrowd	3.81
Bluespire	3.68
TigerConnect	2.92
Medecision	3.19
MTX Group Inc.	3.17
Variedy	3.10
Care3	3.04

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M E M O R A N D U M

DATE:	May 22, 2019
TO:	Pshyra Jones, Ashley Young, Kelly Rex-Kimmet, Belinda Abeyta, Albert Cardenas, Erica Neal, Christine Sisil, Adriana Ramos, Edwin Poon, Diane Ramos, Lisa Ha
FROM:	Maria Medina, CPPB
SUBJECT:	RFP 19-020 – Mobile Text Messaging Services

EVALUATION PROCESS INSTRUCTIONS:

IMPORTANT….If you are contacted by any vendor regarding this RFP process, please do not speak with this vendor and forward all calls to my attention.

Step One: ***Review all Proposals***. Evaluation committee members were provided with copies of each RFP response to begin their individual review of the Proposals. **Take notes, make comments and/or prepare questions for discussion.** Do not score at this point.

Step Two: ***Determine status***. Make an initial determination as to whether each Proposal is "responsive" or "non-responsive." A "responsive" proposal conforms in all material respects to the RFP. A proposal may be deemed "non-responsive" if essential required information is not provided, the submitted price is found to be excessive or inadequate as measured by criteria stated in the RFP, or the proposal is clearly not within the scope of the project described and required in the RFP. *Extreme care should be used when making this decision because of the time and cost that a vendor has put into submitting a proposal. If a proposal is determined to be "non-responsive," it will not be considered further. The Purchasing department will make the final determination of responsiveness. If a determination of "non-responsiveness" is made, written justification must be provided for this conclusion.*

Step Three: ***Score proposals.*** Committee members should **INDIVIDUALLY** score the proposals based on the criteria established within the RFP. Please send me your individual scores by **12:00 Noon, June 5, 2019.** I will prepare a summary team score for all scorers.

Step Four: ***Evaluation Committee Meeting***. Once the proposals have been evaluated and scored by the individual committee members, the entire committee will meet to discuss the proposals and arrive at the final scoring. The committee should discuss all aspects of the proposals so that there is a "unified understanding" of the criteria and corresponding responses. Individual scores may be adjusted at this point based upon discussion. If any of the scores change I will prepare a new summary team rating. The highest score on the Summary Team score will be awarded the business.

Step Five: ***Discussion/Negotiation.*** This step is optional. If the committee is unsure of certain items or issues included in the RFP response, it may request further clarification from the vendor. The Purchasing department will distribute clarification questions to applicable vendor/s. Upon receipt of the vendor responses, the Purchasing department will distribute to the committee members.

Step Six: ***Best and Final Offer.*** This step is optional. A letter asking the vendors to submit a "Best and Final Offer" may be issued by the Purchasing department at the request of the evaluation committee. Once a "Best and Final Offer" is received, the committee will evaluate it in the same manner as the original Proposal.

Step Seven: ***Recommendation and Review.*** After the final scores from the above steps are tallied, the Purchasing department will contact the successful vendor and initiate the agreement process. Upon contract execution, the Purchasing department will notify the remaining vendors, informing them of our decision to award the business elsewhere.

PROPOSAL RATING INSTRUCTIONS:

The attached proposal evaluation form is to be used to initially rate and score proposals. Please enter your scores in the "raw score" fields of the Evaluation Score Sheet. *Please forward to my attention, an electronic version of your completed Evaluation Score Sheet no later than* ***12:00 Noon, June 5th****. The initial results will be presented at the meeting and will form the basis of our discussion.*

- EVALUATION CRITERIA

  Evaluation criteria and respective weights are as follows:

Evaluation Criteria	**Raw Possible Points**	**Weight Factor**	**Total Possible Score**
Letter of Transmittal Requirements, Proposal Organization, completeness of response	5	10%	0.50
Process: Vendor can perform all aspects of the Contract, knowledge of industry, proper qualifications, can handle our size and needs	5	25%	1.25
Related experience: Years, Worked with Vendors similar to CalOptima, References	5	20%	1.00
Account Team: Qualifications, Location, Experience	5	15%	0.75
Price	5	20%	1.00
Contract Changes (Purchasing Only)	5	10%	0.50

  With the four different evaluation criteria, there is a total of 30 "raw points" available for each Proposal. Each evaluation criteria has been weighted in proportion to its perceived value to the overall score.

  Each criterion should be rated separately from the others. In other words, if vendor "A" appears highly capable of effectively completing the project/providing the service, has very good qualifications and related experience, but in your opinion, does not have competitive rates, you should not downgrade your score for the first two criteria as punishment for not doing well on the other criteria categories. It is perfectly acceptable to give vendor "A", a higher score for the first two criteria, and a lower score on the other applicable criteria.

  The Evaluation Team will only need to input their scores in the rows entitled "raw score" of the attached electronic Evaluation Score Sheet.

- PROPOSAL CRITERIA RATINGS (0-5)

  Please rate each Proposal on a scale of 0-5 for each evaluation criteria. This scale and the meaning of the ratings are as follows:

  5 - Outstanding - far exceeds minimum requirements, offers prospects of extremely high-quality work product.

4 - Very Good - exceeds minimum requirements, offers prospects of very high work product.

3 - Good - meets minimum requirements, although there are deficiencies which may result in some flawed work products.

2 - Barely adequate - several deficiencies which may result in flawed work product.

1 - Deficient - does not meet requirements, poses virtual certainty of high risk of flawed products and generally inadequate performance.

0 - Totally non-responsive and noncompetitive to the RFP.

- SCORE (Maximum 5 points)

  Raw Possible Points Evaluation Rating x Weight/Factor = Total Possible Score
  The maximum weighted score for any given Proposal is 5 points.

Reminder….. The EVALUATION MEETING is scheduled for June 6th from 1:00pm – 2:00pm in conference room 802-S

I can be reached on ext. 8659 for any questions. Thank you.

Scope of Work

I. OBJECTIVE

CalOptima is seeking a CONTRACTOR to provide Mobile Text Messaging services to enhance member engagement. The successful Offeror must support CalOptima in implementing a secure communication program designed to close gaps in care, improve quality scores, drive higher engagement and satisfaction for CalOptima's members.

The successful Offeror will provide technology platform for managing outreach to CalOptima's members via text message. The interactive messages must operate as a reliable, secure, and high-speed messaging system of use in the health care environment.

II. MEMBERSHIP

CalOptima's membership is provided for reference only.

CalOptima Membership*

Program	Description	Members
Medi-Cal	California's Medicaid Program for low-income children, adults, seniors and people with disabilities	689,641
OneCare Connect	Medicare-Medicaid Plan for people who qualify for both Medicare and Medi-Cal, combining Medicare and Medi-Cal benefits, adding supplemental benefits for vision, transportation and dental services, and providing comprehensive care coordination	14,104
OneCare	Medicare Advantage Special Needs Plan for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal	1,417
PACE	Program of All-Inclusive Care for the Elderly for older adults, providing comprehensive health services through the CalOptima PACE center	394

**Membership Data as of January 31, 2020*

III. REQUIREMENTS

A. Comply with all state and federal regulations, including but not limited to FDA, Affordable Care Act (ACA), Centers for Medicare and Medicaid Services (CMS), the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). **The Contractor shall be required to sign a Business Associate Agreement (BAA) prior to the commencement of the Contract.**

B. **MOBILE TEXT MESSAGING**

1. Text Campaign Strategy

   a. Successful Offeror's mobile text messaging services must be able to support specific initiatives to help increase member engagement and communications between CalOptima andthe member and. Please describe and/or provide any

samples to demonstrate how the Successful Offeror can support the following with targeted texting strategies:

- Quality Improvement (i.e. preferable experience in assisting health plans with improving HEDIS measures, preventive care, medication adherence, wellness, disease management, etc.)
- Health Plan Navigation Support (i.e. providing information on health care benefits, how to access CalOptima's programs or services such as Nurse Advice Line, assisting new enrollees on how to choose a doctor, etc.)
- Surveys to measure member satisfaction with CalOptima's services

2. Text Messaging Features
   a. Please describe the messaging features that are supported by the Successful Offeror. At minimum, they should include:
      - Text blasting/bulk messaging
      - Two-way text messaging
      - Tailored or personalized text messages
      - Automated responses
      - Keywork responses
      - Conditional branch logic (allow for keyword and automated responses based on predefined algorithm)
      - Message scheduling/staggering
      - Message queuing
      - Active links
      - Voting and polling
      - Short codes
      - Unicode support

3. Content

   a. Content must be written at a sixth-grade reading level or below to ensure the information is easy to understand. Please provide any details related to content development, required approvals, and customization options.

4. Enrollment

   a. Successful Offeror shall have policies and proecuedres for managing the users opt-out/opt-in and text preferences.

   b. Successful Offeror must be able to support CalOptima with identifying mobile numbers and land line numbers to distinguish users who are able to receive text messages.

IV. DATA EXCHANGE, SECURITY, AND SYSTEM INTERFACE REQUIREMENTS

A. The Successful Offeror must have a Health Insurance Portability and Accountability Act (HIPAA) compliant platform and secure encryption texting capability to ensure the safe management of Protected Health Information (PHI) and other sensitive data. Please share the process, policies and/or procedures Successful Offeror will follow to ensure HIPAA regulations are met and certified as HIPAA compliant.

B. Successful Offeror shall have the ability to handle eligibility files and to download from CalOptima's FTP site. It shall also have the ability to take the eligibility files and set-up a system load.

C. Successful Offeror must ensure that all data is kept for ten (10) years at minimum.

D. Successful Offeror agrees, upon termination of the relationship (regardless of which party terminates), to provide all information required for successful transition files at no additional cost.

V. CULTURAL AND LINGUISTICS

A. CalOptima supports seven (7) "threshold" languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese, and Arabic. Successful Offeror shall have ability to support mobile text messaging services in English and Spanish, at minimum. Please list any other languages that are supported by the Sum.

VI. REPORTING

A. Successful Offeror's reporting mechanisms should be able to provide real-time updates of text message delivery and campaign performance. Describe what information is captured on these reports.

B. Summary reports shall be provided at the conclusion of each text campaign that measures performance and outcomes. Describe the report features and the data elements that are captured.

C. Reports should be in a format that allows data to be integrated into CalOptima systems. How will data be shared with CalOptima (i.e. web portal, secure email, FTP transfer, etc)?

D. Does the Offeror include any analysis in the standard reporting package?

E. All offerors shall provide a sample copy of the reports with its proposals.

VII. SERVICE LEVEL AGREEMENT (SLA)

What Service Level Agreements and warranties does your company provide? Please provide detail levels and metrics. Include a specific time element offered.

VIII. IMPLEMENTATION SCHEDULE

Offeror shall provide an implementation timeline, including benchmarks and milestones as part of its response.

IX. PRICING MODEL

Offeror shall provide pricing model/structure for implementation, services provided and any other fees CalOptima may incur.

TEXTING PROGRAM & CAMPAIGN

SUBMISSION FORM

INSTRUCTIONS:
This form is required for all Medi-Cal managed care plans' (MCP) texting program and/or its individual texting campaign(s). Complete this form, including the Indemnification Agreement and email it to your DHCS Contract Manager for approval. DHCS will review and respond within 60 days of submission of the form.

Email subject line must include "For your approval: MCP name, Subplan name if applicable, Texting, and Campaign(s). For example:

- For a campaign submission: "For your approval: PlanA_Texting_New Member Orientation"
- For multiple campaigns submission: "For your approval: PlanA_Texting_Multiple Campaigns"

MCP is required to complete **all sections (Sections A-C)** when MCP first seeks an approval for a new Texting Program. Once MCP's new texting program has been approved and MCP would like to add additional campaigns, MCP will need to complete **Section A** and **Section C** only.

MCP can replicate **Section C** for additional campaigns if MCP desires to submit multiple campaigns for approval at the same time.

As a condition of approval for any text messaging campaign, a designee within the MCP who holds signatory authority is required to execute the attached Indemnification Agreement. Approval of the campaign is not considered final until the MCP receives a signed copy of the Indemnification Agreement back from the DHCS.

Key definitions

1. Texting Program: MCP's overall program design and infrastructure utilized to implement individual text messaging campaigns.
2. Texting Campaign: MCP's specific text message(s) aimed to address an identified objective (e.g., Preventive Care Reminders, New Member Orientation, etc.).

SECTION A: GENERAL INFORMATION

1. Managed Care Plan: _____ Date: _____
2. Submitted on behalf of a subcontracting MCP: _____ ☐ N/A
3. List the county or counties where you conduct your texting campaign(s):

   _____

SECTION B: TEXTING PROGRAM POLICY & PROCEDURE

1. Does the MCPs policy describe the process the MCP will use to obtain Members' Agreement to Participate (i.e., release of information) either through active opt-in or assumed opt-in approach and explain how a member can opt-out and the timeline associated with processing such requests? Please attach MCP's program policy and procedure (PnP) and process workflow. If no, please describe.

   ☐ Yes

   ☐ No

2. Does MCP's policy describe any financial costs that MCP's Members may incur from receiving the Agreement to Participate message(s) and any potential costs of future messages? If no, please describe.

   ☐ Yes

   ☐ No

3. Is the MCPs proposal related to redetermination outreach?

   ☐ Yes

   ☐ No

If yes, does the MCPs policy indicate outreach will only be made to members who are on the MCPs monthly 834 file showing an HCP status of 05?

☐ Yes

☐ No

4. Has the MCP provided texting script(s) to obtain MCP's Members' Agreement to Participate, or texting script(s) to allow MCP's members to opt-out?

☐ Yes

☐ No

5. Are the texting script(s) provided to members at the sixth grade reading level, per Exhibit A, Attachment 13, 4(C) of the contract with DHCS?

☐ Yes

☐ No

6. Does the texting script have any health education information? If yes, has the campaign script been reviewed and approved by the MCP health educator in accordance with APL 18-016?

☐ Yes

☐ No

7. Does the MCPs policy describe how the MCP considers privacy concerns and custody/guardianship situations based upon information available to MCP? If no, please describe.

☐ Yes

☐ No

8. Does the MCPs policy describe how the MCP protects Members' PII and/or PHI and meet requirements of Exhibit G of the contract with DHCS? If no, please describe.

☐ Yes

☐ No

9. Is the MCP using a third-party vendor? If yes, who is the vendor? If MCP has not already sent the vendor's Master Service Agreement and all contract amendments to DHCS, attach them to this application.

☐ Yes

☐ No

10. Does the vendor's Master Service Agreement comply with all applicable state and federal law and contract requirements in particular, Exhibit G of the contract with DHCS?

☐ Yes

☐ No

SECTION C: [SPECIFIC TEXTING CAMPAIGN NAME]

1. What is the overall purpose of campaign? Circle one.
    a. Providing health education information
    b. Providing written member information
    c. Reminding of preventive care visits
    d. Supporting statewide regulatory efforts on digital communications
    e. Other(s): _____

    Disclaimers: MCP certifies that any health education information provided through the campaign has been reviewed and approved by the MCP health educator in accordance with APL 18-016.

    Information on eligibility redetermination cannot be included in text campaign.

2. Describe the objectives of the campaign.

3. Does the campaign include any member incentives?

    ☐ Yes

    ☐ No

    If yes, has the incentive been reviewed and approved by DHCS health educators in accordance with APL 16-005?

    ☐ Yes

    ☐ No

4. Does the campaign include Personal Identification Information (PII) and/or Protected Health Information (PHI)? If yes, confirm the answer to question 7 in Section B above is checked "yes."

    ☐ Yes

    ☐ No

5. Who is the campaign's target population?

6. Who will be excluded from the campaign based upon information available to MCP (e.g., Members with SUDS, HIV/AIDS, behavioral health, minors in family planning, etc.)?

7. Does MCP require additional Members' Agreement to Participate for this specific texting campaign (i.e., extra opt-in requirement for sensitive services or PHI/PII content)?

   ☐ Yes

   ☐ No

8. What is the campaign length? When will it start and end?

9. What is the frequency of text messaging?

10. In what language(s) will the campaign be available? Will members have an option to receive text messages in their primary language (i.e. Spanish)?

11. Provide content script of the campaign.

12. What is the expected outcome of the campaign?

Attestations:

☐ For new campaign submission only (Section C), MCP attests that the Texting Program submission (Section B) that was previously approved contains no changes. Each new campaign will require an executed Indemnification Agreement.

☐ For ongoing texting programs, MCP will report to the DHCS Contract Manager the outcomes of plan texting campaigns on an annual basis, 45 days from the annual anniversary of the campaigns initiation. For time-limited campaigns, MCP will report outcomes six months after a program ends.

FOR DHCS USE ONLY (OR USE ALTERNATE DHCS AIR FORM)

1. DHCS Reviewer's Name: _____ Date: _____
2. DHCS Reviewer's Title: _____
3. DHCS Reviewer's Decision:

☐ Approved as submitted

☐ Approved with the following changes:

_____

☐ Denied

Reason (s): _____

_____

☐ Request for more information: _____

_____

_____

TEXT MESSAGING CAMPAIGN INDEMNIFICATION AGREEMENT

In consideration of the Department of Health Care Services' approval of [INSERT HEALTH PLAN NAME's] text messaging program, [INSERT HEALTH PLAN NAME] agrees to indemnify, defend and hold harmless the State, DHCS and its officers, agents and employees from any and all claims and losses, any and all attorneys' fees and costs, judgments, damages, any administrative costs incurred to the extent DHCS is required to provide notice to affected beneficiaries and any other costs associated with any actual or alleged breach of 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 U.S.C. section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 and the Information Practices Act, California Civil Code section 1798 et seq. by [INSERT HEALTH PLAN NAME] and any vendor, contractor, subcontractor that [INSERT HEALTH PLAN NAME] contracts with for the approved text messaging campaign.

_____	_____
Health Plan Representative	DHCS Contract Manager
_____	_____
Date	Date

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 7, 2019
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of CalOptima Population Health Management Strategy for 2019

Contact

David Ramirez, M.D., Chief Medical Officer, (714) 246-8400
Betsy Ha, Executive Director, Quality and Analytics, (714) 246-8400

Recommended Action

Consider approval of the CalOptima Population Health Management Strategy for 2019.

Background

The National Committee for Quality Assurance (NCQA) continuously assesses the health care landscape, as well as pending regulations, to enhance accreditation standards annually. Effective July 1, 2018, NCQA implemented a significant change by creating a new Population Health Management (PHM) Standards section (see Attachment 2). Concurrently, NCQA eliminated the Disease Management standards, moved Complex Case Management (CCM) Standards from the Quality Management & Improvement Standards (QI) section, and Wellness and Prevention Standards from the Member Connections Standards (MEM) section to the PHM section. The PHM section also included new standards requiring health plans to provide Delivery System Supports, such as providing transformation support to the primary care practitioners. The comprehensive PHM Strategy is the first structural requirement of the new standard set. In preparation for the next NCQA re-accreditation and onsite audit scheduled for July 11-12, 2021, CalOptima must start implementing the PHM Strategy with appropriate resource alignment starting on May 24, 2019 upon Board approval.

Discussion

The intent of the CalOptima PHM Strategy for 2019 is to develop a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

The year one approach of the CalOptima PHM Strategy is to align current and new programs (e.g., Bright Steps, Behavioral Health Integration, Whole-Child Model, Complex Case Management, and Health Management Programs, etc.) to the new PHM framework leveraging internal and external population health needs assessment findings to date. The PHM plan of action as part of the Quality Improvement (QI) Work Plan is updated annually through the comprehensive annual QI Program and Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflect the changing demographics and local population needs of the Orange County community.

Back to Item Back to Agenda

The PHM Strategy addresses four focus areas:

1. Keeping members healthy
2. Managing members with emerging risk
3. Patient safety or outcomes across all settings
4. Managing multiple chronic conditions.

Building upon the current high touch Model of Care and expanding its relevant care components to provide access to quality health care services to a broader member population, the CalOptima PHM Strategy proposed innovative ways to provide members with access to quality health care services leveraging secured virtual technology. CalOptima will be testing the feasibility of various telehealth use cases, ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in member's home.

Additionally, the PHM Strategy proposed new strategies to support providers in the delivery system transformation.

1. Practice Site Transformation - Develop CalOptima Quality Improvement nursing expertise to serve as Quality Advisors or Practices Facilitators to provide individualized technical assistance to improve member experience and patient safety at the practices starting with high volume safety net community centers.
2. Expand Provider Coaching and Leadership Development - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices with high incidences of Quality of Services (QOS) grievances.

Fiscal Impact

There is no additional fiscal impact for the recommended action to approve the CalOptima PHM Strategy for Calendar Year 2019. The Fiscal Year 2018-19 Operating Budget approved by the Board on June 7, 2018, included funding to start implement the PHM Strategy by May 2019.

Rationale for Recommendation

These recommendations reflect alignment between CalOptima Population Health Strategy with the NCQA's new standards to provide integrated quality healthcare services to CalOptima's population at large, including those members who are currently healthy and low emerging risk. The timely implementation of the PHM Strategy by May 2019, will position CalOptima well to achieve NCQA re-accreditation aiming for Excellence accreditation status in 2021.

Concurrence

Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments

1. CalOptima Population Health Management (PHM) Strategy for 2019
   a. 2018 NCQA PHM Standards
2. 2019 NCQA PHM Standards and Guidelines
3. PowerPoint Presentation to Board of Directors' Quality Assurance Committee: CalOptima PHM Strategy - 2019 Overview

/s/ Michael Schrader *1/30/2019*
Authorized Signature **Date**

CalOptima Population Health Management (PHM) Strategy

PHM Strategy Description [PHM1 A]

BACKGROUND

Who We Are

Orange County is unique in that it does not have county-run hospitals or clinics. CalOptima was created in 1993 by a unique and dedicated coalition of local elected officials, hospitals, physicians, and community advocates. It is a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal (Medicaid) benefits in Orange County, and is the largest COHS nationwide. As a public agency, CalOptima is governed by a Board of Directors with voting members from the medical community, business, county government and a CalOptima member. CalOptima's mission is to provide members with access to high quality health services delivered in a cost-effective and compassionate manner.

CalOptima contracts with the State of California Department of Health Care Services (DHCS) to arrange and pay for covered services to Medi-Cal members, and also contracts with the Centers for Medicare & Medicaid Services (CMS) for Medicare-reletad programs. As of October 2018, CalOptima's total membership is more than 775,000, which includes members in Medi-Cal; a Medicare Advantage SNP; a Cal MediConnect Plan (Medicare-Medicaid); and the Program for All-Inclusive Care for the Elderly (PACE).

Medical services are delivered to CalOptima's Medi-Cal members through a variety of contractual arrangements. As of May 2018, CalOptima contracts with 13 health networks, including four Health Maintenance Organizations (HMOs), three Physician/Hospital Consortia (PHCs) composed of a primary medical group and hospital, and five Shared Risk Medical Groups (SRGs). CalOptima is able to fulfill its mission in Orange County because of its successful partnership with its outstanding providers.

Intent

CalOptima has a comprehensive plan of action for addressing our culturally diverse member needs across the continuum of care. The community driven plan of action is based on numerous efforts to assess the health and well-being of CalOptima members. The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole-person-centered, safe,

effective, timely, efficient, and equitable manner across the entire health care continuum and life span.

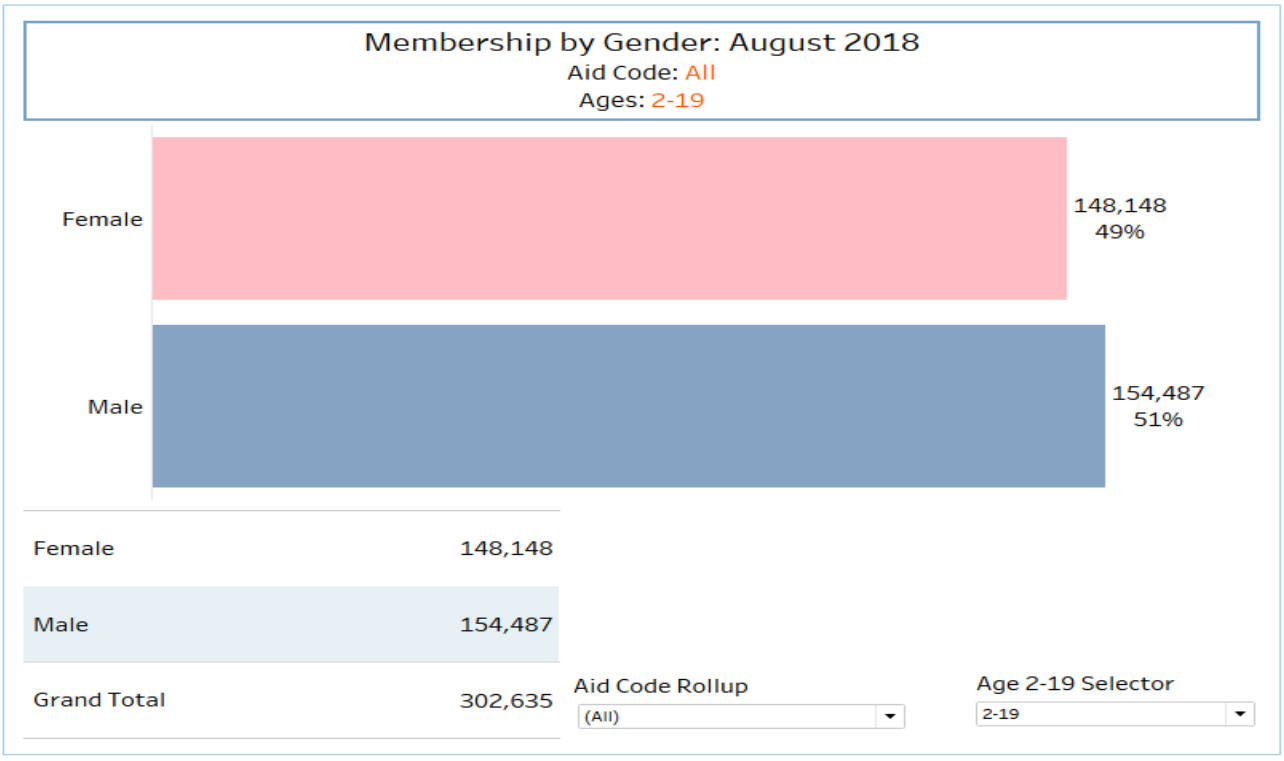
- **CalOptima's Target Population**
  - **Population Identification [PHM2]**
    - CalOptima identifies and assesses its population through a variety of efforts and uses the findings for appropriate interventions. One of many sources that the PHM Strategy is based upon is the Member Health Needs Assessment that was completed in March 2018. It focused on ethnic and linguistic minorities within the Medi-Cal population from birth to age 101. The PHM plan of action addresses the unique needs and challenges of specific ethnic communities, including economic, social, spiritual, and environmental stressors, to improve health outcomes. The PHM plan of action, as part of the Quality Improvement (QI) Work Plan, is updated annually through the comprehensive annual QI Program Evaluation process. In addition to the cost and quality performance data sets, CalOptima's PHM strategy is adjusted annually based on the analysis of other data sources that reflects the changing demographics and local population needs of the Orange County community. Since CalOptima members represent 25% of Orange County residents, other examples of external reports used to help identify trends that may impact CalOptima population are identified below.
      - The 2016 Orange County Community Indicators Report
      - The 2017 Conditions of Children in Orange County Report
      - Children eligible for California Children's Services (CCS) Report from the county CCS Program
      - Prenatal Notification Report (PNR)
  - **Data Integration [PHM2 A]**
    - CalOptima integrates multiple internal and external data sources in its data warehouse to support population identification and various PHM functions. Some examples of internal and external data sources are:
      - Member data from the Department of Health Care Services (DHCS)
      - Medical and Behavioral claims from DHCS and Orange County Health Care Agency (OC HCA) Mental Health inpatient claims
      - Encounters data from contracted health networks
      - Pharmacy claims
      - Laboratory claims and results from Quest and LabCorp
      - Other advanced data sources (e.g., member data of homeless status from Illumination Foundation, Regional Center of Orange County, Utilization Management (UM) authorization data, and qualitative data from health appraisals)

- **CalOptima Population and Sub-Population Segments [PHM2 B]**
  - In addition to external data sources, CalOptima leverages Tableau, an enterprise analytic platform, for segmenting and stratifying our membership, including the subsets to which members are assigned (e.g. high-risk pregnancy, multiple inpatient admissions, co-morbid conditions, disabilities, polypharmacy, high risk and high cost cases, transgender population etc.). The Enterprise and Quality Analytics departments provide standard and ad hoc reports specifying the numbers of members in each category and the programs or services for which they are eligible.

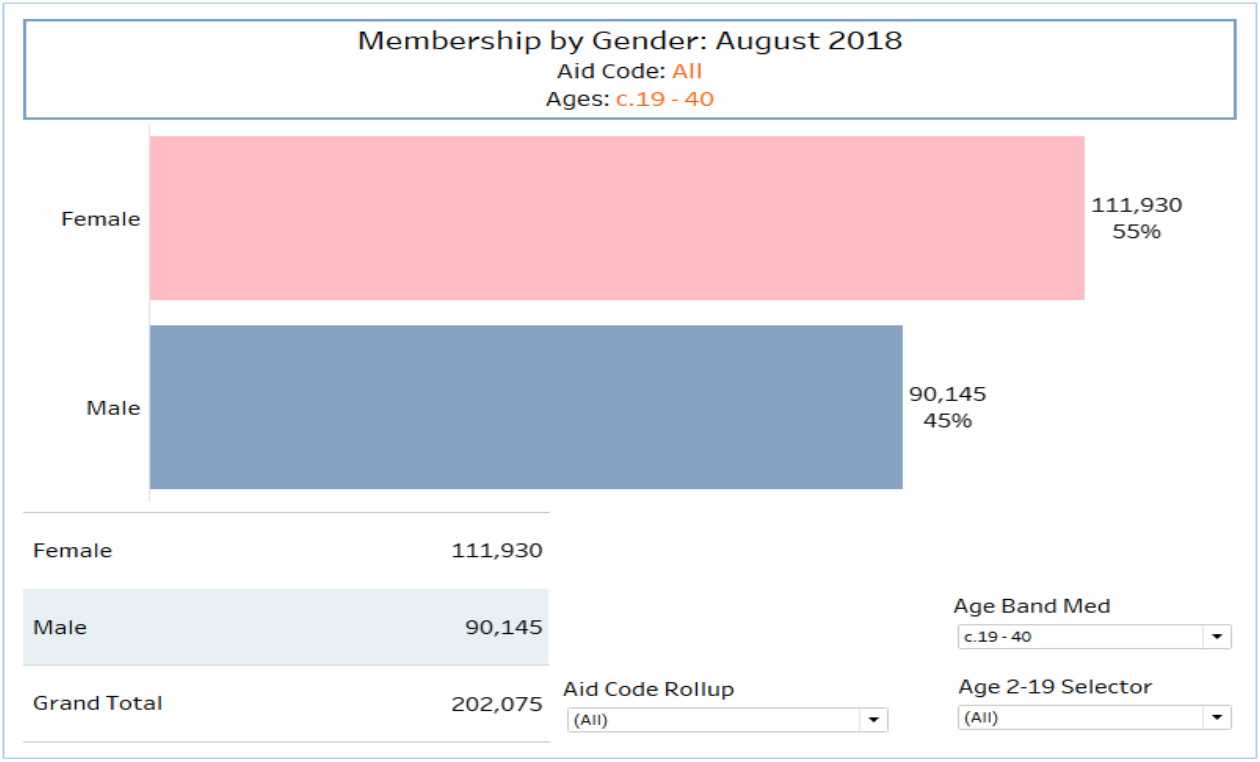
    Example of Member Segmentation – *Source: Tableau_f_dx_v33_m95_08.24.18*

  - *By Age and Gender*

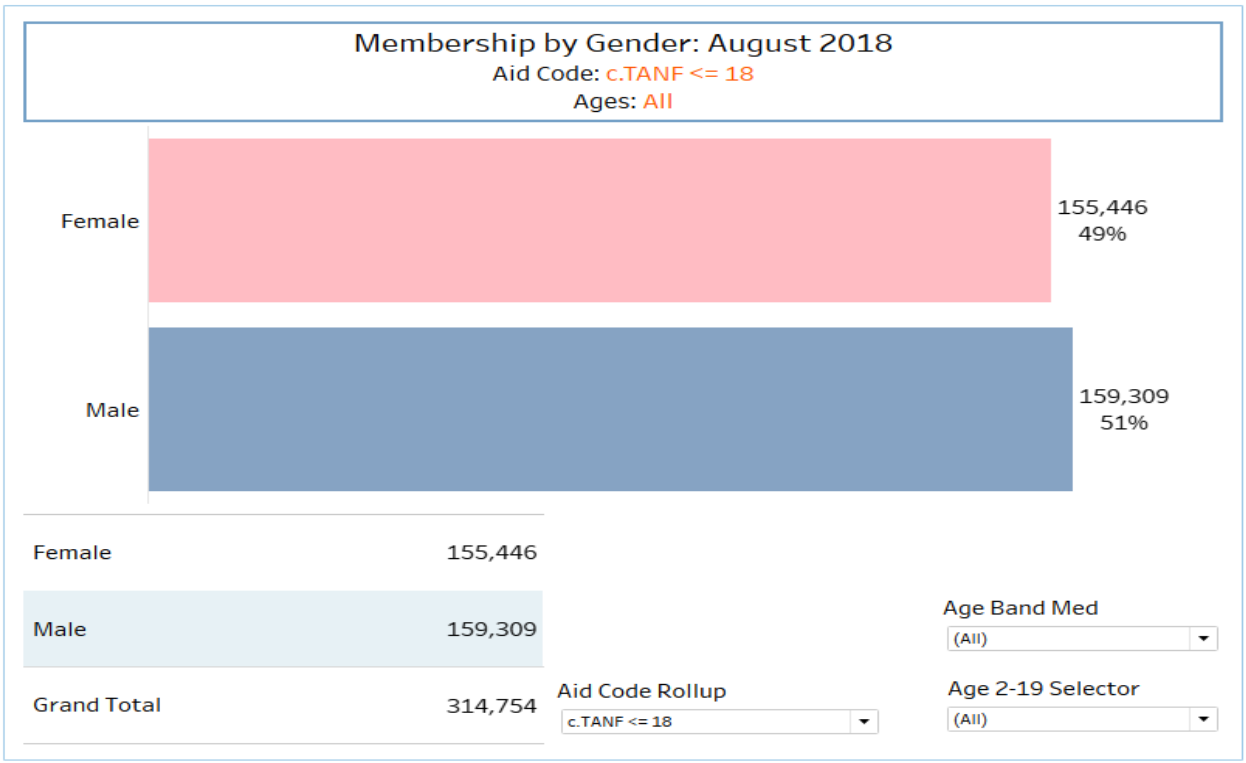
    - *Ages 2–19*



- *Adults 19–40*

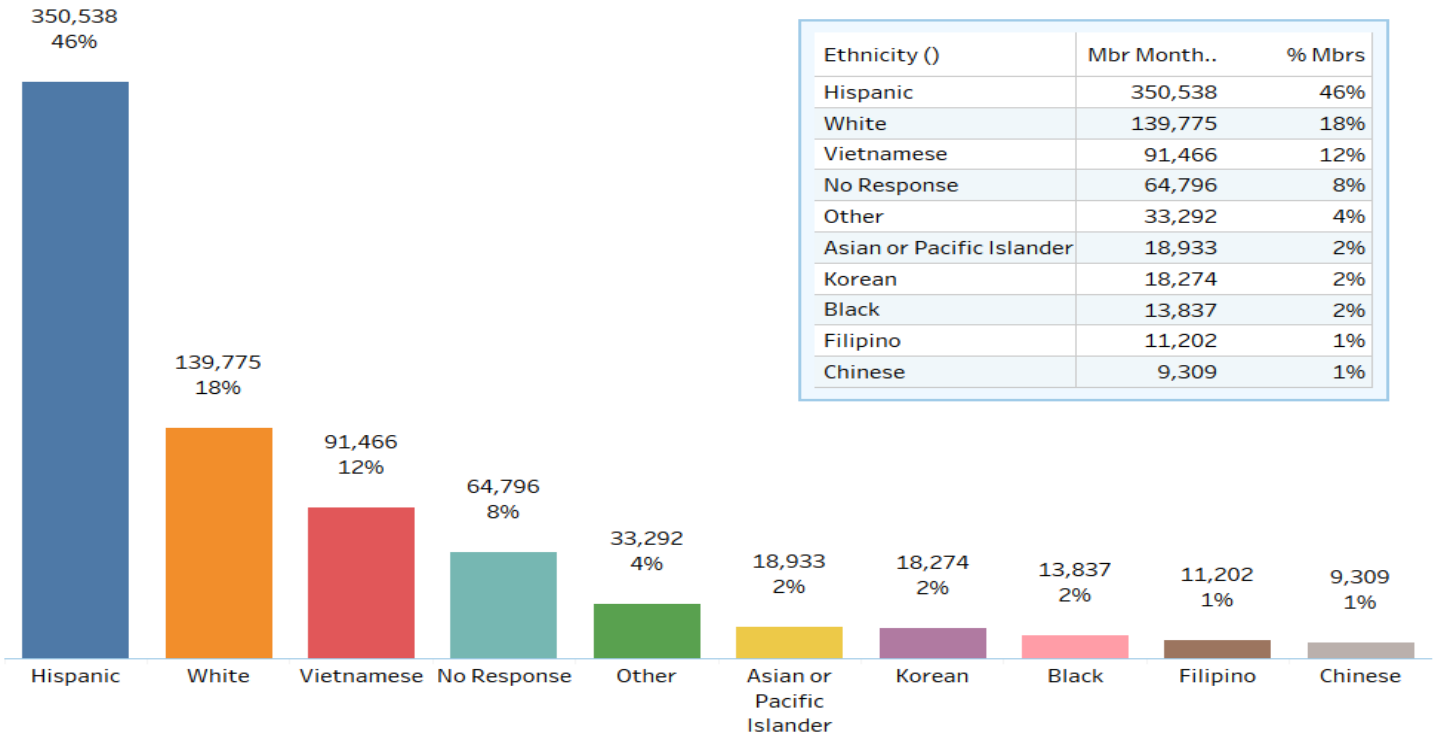


- *TANF (<18 Non-SPD)*



- *Ethnicity*

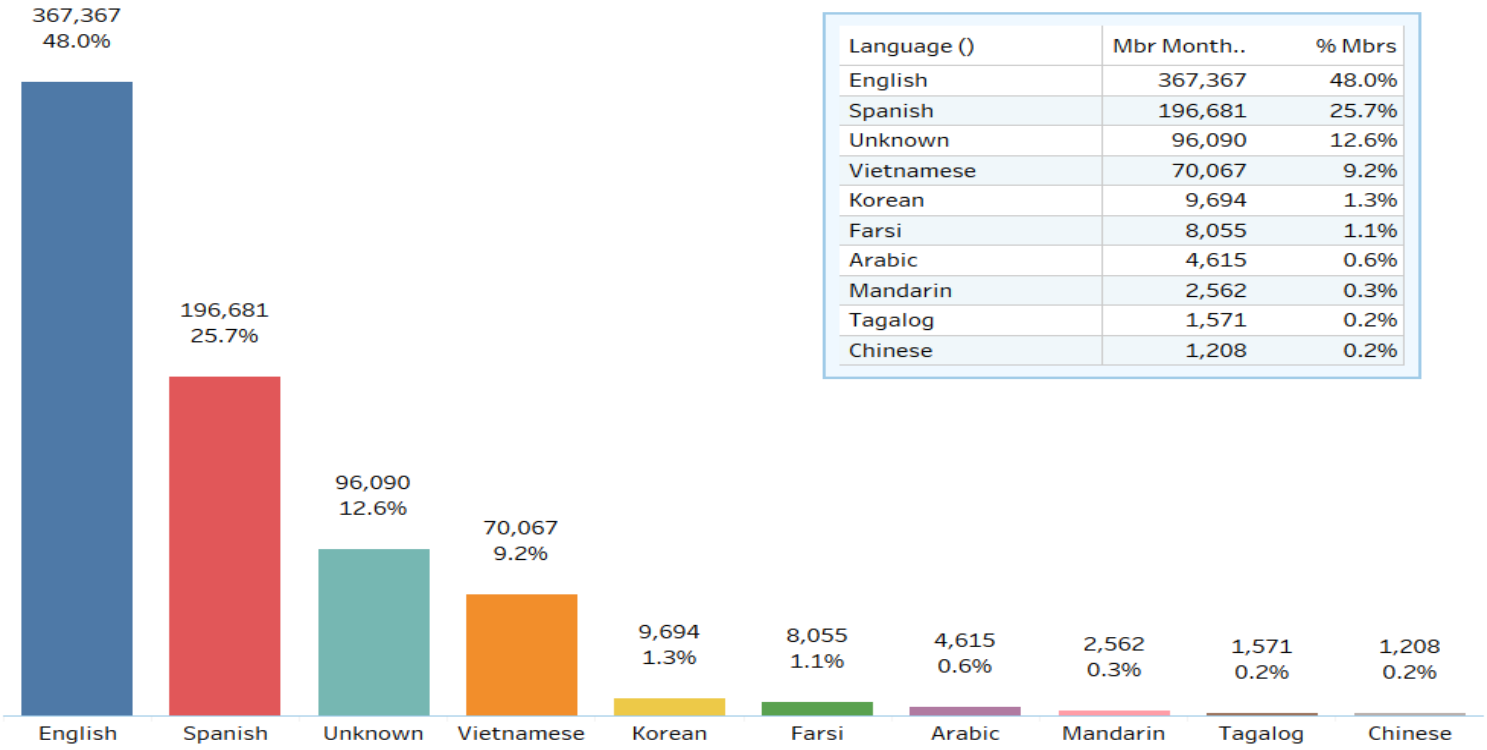
CalOptima Top Ten Member Ethnicities
Aid Code: All
Ages: All
Total Members: 764,774



Ethnicity ()	Mbr Month..	% Mbrs
Hispanic	350,538	46%
White	139,775	18%
Vietnamese	91,466	12%
No Response	64,796	8%
Other	33,292	4%
Asian or Pacific Islander	18,933	2%
Korean	18,274	2%
Black	13,837	2%
Filipino	11,202	1%
Chinese	9,309	1%

- *Language*

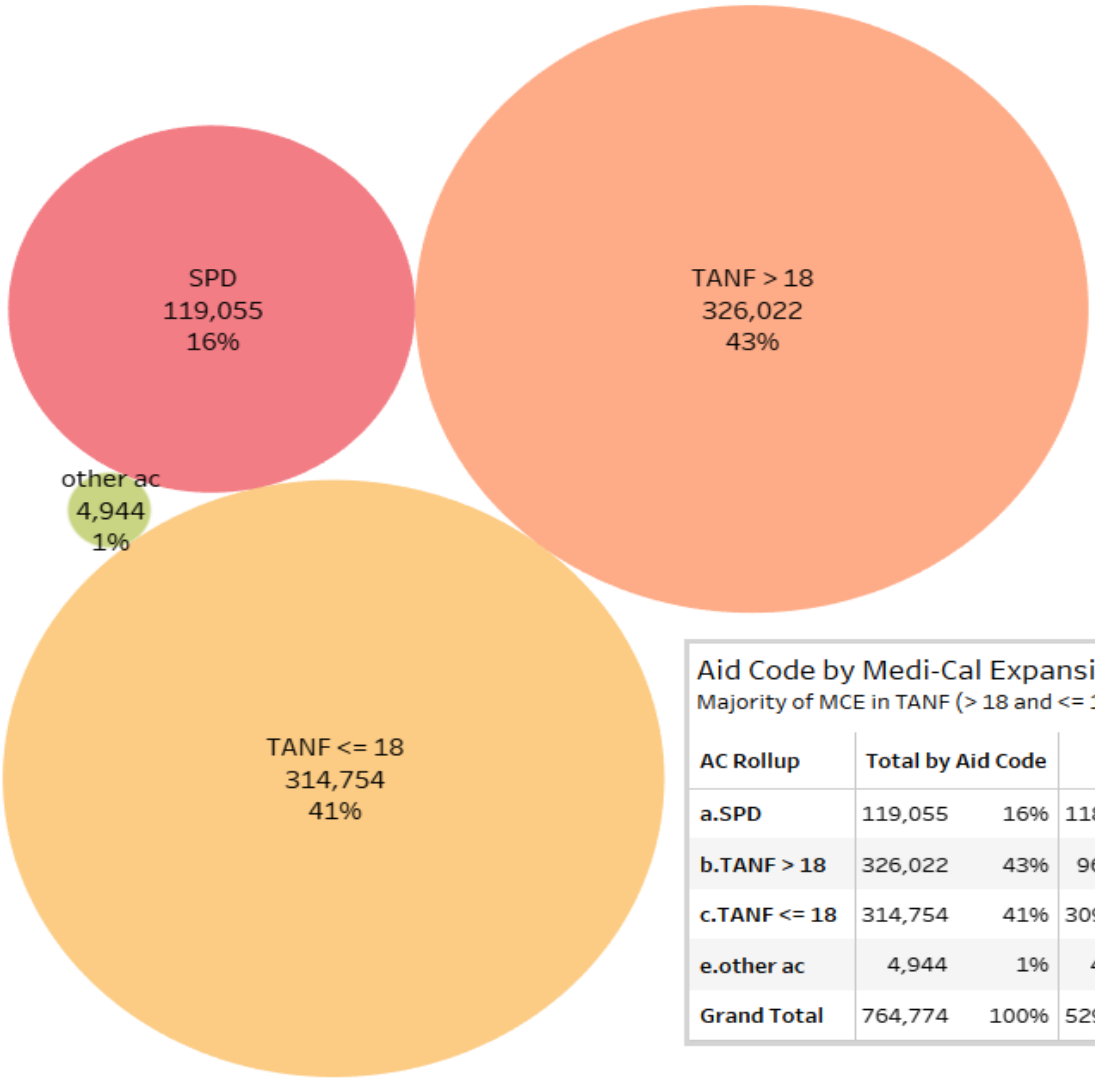
CalOptima Top Ten Member Languages
Aid Code: All
Ages: All
Total Members: 764,774



Language ()	Mbr Month..	% Mbrs
English	367,367	48.0%
Spanish	196,681	25.7%
Unknown	96,090	12.6%
Vietnamese	70,067	9.2%
Korean	9,694	1.3%
Farsi	8,055	1.1%
Arabic	4,615	0.6%
Mandarin	2,562	0.3%
Tagalog	1,571	0.2%
Chinese	1,208	0.2%

- *By Aid Code*

Membership by Aid Code: August 2018

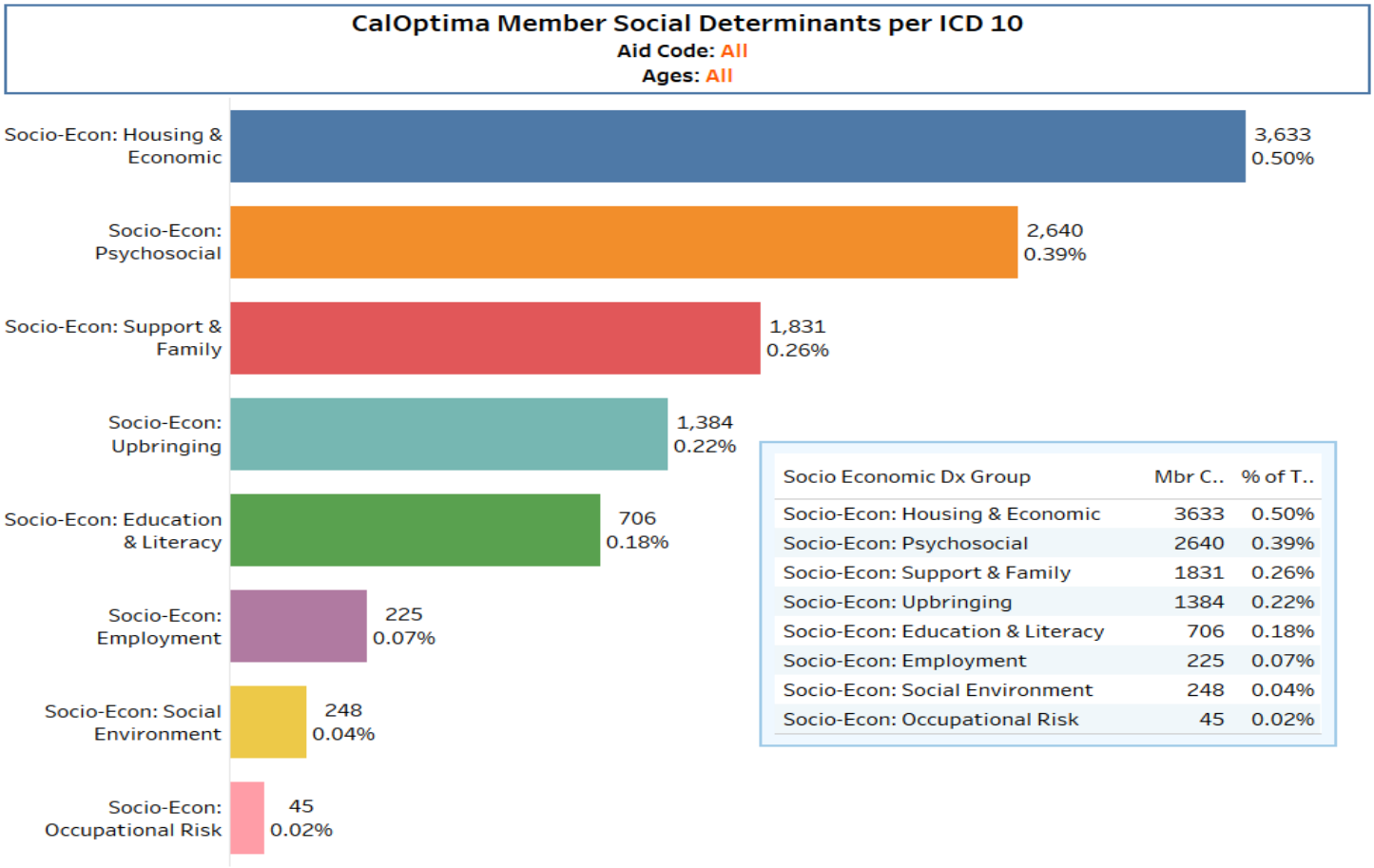


Aid Code by Medi-Cal Expansion (MCE)

Majority of MCE in TANF (> 18 and <= 18) aid codes

AC Rollup	Total by Aid Code		Not MCE		MCE	
a.SPD	119,055	16%	118,657	22%	398	0%
b.TANF > 18	326,022	43%	96,110	18%	229,912	98%
c.TANF <= 18	314,754	41%	309,583	58%	5,171	2%
e.other ac	4,944	1%	4,944	1%		
Grand Total	764,774	100%	529,294	100%	235,481	100%

- *Social Determinants*



Socio Economic Dx Group	Mbr C..	% of T..
Socio-Econ: Housing & Economic	3633	0.50%
Socio-Econ: Psychosocial	2640	0.39%
Socio-Econ: Support & Family	1831	0.26%
Socio-Econ: Upbringing	1384	0.22%
Socio-Econ: Education & Literacy	706	0.18%
Socio-Econ: Employment	225	0.07%
Socio-Econ: Social Environment	248	0.04%
Socio-Econ: Occupational Risk	45	0.02%

➢ **Other Sub-Populations**
- Women during pregnancy
- Children with obesity
- Children with California Children's Services (CCS) eligible condition
- Children and adults with autism
- Adult with disability and chronic conditions
- Persons with substance abuse disorder
- Persons requiring organ transplants
- Person with multiple chronic conditions and homelessness
- Frail elderly adults at risk for institutional care
- Transgender population
- Persons at end of life

❖ **Population Assessment [PHM2 B]**

➢ CalOptima conducts an annual population health risk assessment through analysis of quality performance trends, including Healthcare Effectiveness Data and Information Set (HEDIS) results, member experience surveys in all threshold languages by Health Networks, members complaints and grievances trends, and

inpatient utilization trends. To date, CalOptima serves eligible Medi-Cal beneficiaries from birth to 111 years of age! CalOptima serves a broad spectrum of population with health care needs from the cradle to the grave. Our population segments include well infants, children, adolescents, young adults, pregnant mothers, children with disabilities, children with CCS conditions, well adults, adults with chronic conditions and disabilities, members with serious and persistent mental illness (SPMI), well seniors, frail elderly with deteriorating functional status, and members residing in long-term care (LTC) facilities. The sub-populations include, but are not limited to, populations with health disparities due to race and ethnicity, transgender identity, food insecurity, and homelessness. As the Orange County demographic assessment changes every five years, CalOptima conducts a comprehensive Member Health Needs Assessment of Orange County residents to assess the characteristics and needs of the member population in the community we serve.

2019 PHM STRATEGY

- **Strategies to Keep Members Healthy [PHM1 A Factor 1, 2]**
  - **Bright Steps — Improve Prenatal and Postpartum Care**
    - **Goal:** Demonstrate significant improvement in prenatal and postpartum care rates to achieve 90th percentile by December 2020
      - Improve 2018 HEDIS Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
      - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
    - **Target Population:** Members in the first trimester of pregnancy newly identified through the pregnancy notification form.
    - **Description of Programs or Services:** CalOptima contracts with certified Comprehensive Perinatal Service Program (CPSP) providers to deliver evidenced-based prenatal and postpartum care to members. Bright Steps is designed to support CalOptima Medi-Cal moms through a healthy pregnancy and postpartum care. Annually the program will be evaluated for increased Prenatal and Postpartum Care (PPC) HEDIS rate, reduced rates for neonatal intensive care unit usage, reduced number of low birth weights and preterm births, and member satisfaction with the program.
    - **Activities:** CalOptima staff provide member outreach and coordination with CPSP providers. In areas with limited CPSP providers, CalOptima staff will provide direct health education and support program interventions aligned with the CPSP guidelines.

- **Shape Your Life — Prevent Childhood Obesity**
  - **Goal:** Maintain 2018 HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for following Children/Adolescents (WCC) measures year-over-year:
    - BMI Percentile (WCC)
    - Counseling for Nutrition (WCC)
    - Counseling for Physical Activity (WCC)
  - **Target Population:** Members age 5-18 with a Body Mass Index (BMI) equal to or above the 85th percentile.
  - **Description of Programs or Services:** CalOptima's Shape Your Life health education and physical fitness activity program aims to increase youth member access to weight management program(s), increase doctor/patient communication regarding healthy weight and nutrition and physical activity counseling, and increase member nutrition and physical activity knowledge and improve behaviors. Annually the program will be evaluated for program effectiveness. Measurement goals include pre/post BMI, knowledge gains (pre/post validated survey) and member satisfaction with program.
  - **Activities:** The program uses the licensed Kids-N Fitness curriculum which is evidenced-based and validated through Children's Hospital Los Angeles. Interventions includes up to 12 group classes, which include nutrition education and physical activity, and an incentive for a follow up visit with provider after 6 consecutive classes. All classes are conducted in members' community using appropriate threshold language of the participants.

- **Strategies to Manage Members with Emerging Risk [PHM1 A Factor 1,2]**
  - **Health Management Programs — Improving Chronic Illness Care Prevention and Self-Management**
    - **Goals:** Develop chronic illness program interventions to support improvements in HEDIS and Member Experience scores
      - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP), and Comprehensive Diabetes Care (CDC)
      - Increase overall Member Satisfaction by improving Rating of All Health Care to 90th Percentile by 2021
      - Reduce ED and IP rates by 3% for program participants in 2018
    - **Target population:** Members discovered to be at risk for Asthma, Diabetes and/or Heart Failure based on primary care physician referral, new diagnosis codes, or pharmacy claims. Specific criteria detailed below.

- Members > 3 (Asthma); Members > 18 (Diabetes, Heart Failure) for Medi-Cal, OneCare, and OneCare Connect line of business
- Two year look back period for Asthma, Diabetes, or Heart Failure Related Utilization
- Exclusion Criteria:
  - Ineligible CalOptima Members
  - Members Identified for LTC or diagnosed with Dementia
  - Members Delegated to Kaiser

- **Description of Programs or Services:** CalOptima's Health Management Programs focus on disease prevention and health promotion for members with Asthma, Diabetes and Heart Failure. Health Management Programs are designed to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention. To assess the effectiveness of each Health Management Program, measures are set annually against organization or national benchmark standards. The evaluation takes into consideration program design, methodology, implementation and barriers to provide an analysis with quantitative and qualitative results for CalOptima's population with chronic illness. Measurement goals for each program include improvement in HEDIS measures related to the chronic conditions managed, reduced IP/ED for members with chronic illness, and member satisfaction with health management program.
- **Activities:** Health education using evidence-based clinical practice guidelines and self-management tools, relevant to members for the provision of preventive, acute, or chronic, medical services and behavioral health care services standards and requirements. *(Refer activities list in Policies and Procedures GG.1211.)*

➢ **Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction**

- **Goal:** Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
- **Target Population:** Members with diagnosis of opioid substance abuse disorder
- **Description of Programs or Services:** A multi-departmental and health collaborative aim at reducing opioid misuse and related death.
- **Activities:** Includes, but is not limited to, pharmacy lock-in program, physician academic detailing for safer prescribing, increased access to Medication Assisted Treatment (MAT), and case management outreach.

- **Strategies to Ensure Patient Safety [PHM1 A Factor 1,2]**
  - **Behavioral Health Treatment (BHT) Services**
    - **Goal:** Establishing appropriate program baseline in 2019
    - **Target Population:** Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age, as required by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate.
    - **Description of Programs or Services:** Provide medically necessary BHT services to children with Autism Spectrum Disorder through early identification and early intervention in collaboration with the parents to promote optimal functional independence before aging out of the Regional Center system. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
    - **Activities:** Treatments include direct observation, measurement, and functional analysis of the relations between environment and behavior of children with ASD.

  - **Practice Facilitation Team — Improve Practice Health & Safety Leveraging the QI Practice Facilitators Team**
    - **Goals**: Achieve and sustain 100% compliance in all Facility Site Review (FSR) audits year-over-year for primary care practices.
    - **Target Population:** Medi-Cal adults and children accessing primary care.
    - **Description of Programs or Services:** Enhancing the existing FSR nursing function by training nurses in QI facilitation skills to address any gaps from FSR audits to improve compliance with practice health and safety standards at the practice sites of the CalOptima Community Networks (CCN).
    - **Activities:** CalOptima will develop Practice Facilitator functions for the FSR nurses to identify opportunities to improve practice site health and safety and provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices. CalOptima will coordinate with the community clinics, Federally Qualified Health Centers (FQHC), and eventually expand to other potential settings such as PACE to promote patient safety practices.

- **Strategies to Manage Members with Multiple Chronic Illnesses [PHM1 A Factor 1,2]**
  - **Whole-Child Model — Ensure Whole-Child-Centric Quality and Continuity Care for Children with CCS Eligible Conditions**

- **Goal:** Improve Children and Adolescent Immunization HEDIS measures by 10% from the 2018 baseline by December 2020 (excluding children and adolescent under cancer treatment)
  - Improve Childhood Immunization Status Combo10 for Children with CCS eligible conditions to ≥37.0% (2018 Baseline = 33.3 %)
  - Improve Immunization for Adolescents with CCS eligible conditions to ≥ 50.0% (2018 Baseline = 45.33%)
- **Targeted Population:** Children with CCS Eligible Conditions
- **Description of Programs or Services:** The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results. Currently, children who have CCS-eligible diagnoses are enrolled in and get care from both the county CCS program for their CCS condition and CalOptima for their non-CCS conditions, routine care and preventive health. Beginning July 1, 2019, Orange County Medi-Cal CCS eligible children will receive services for both CCS and non-CCS conditions from CalOptima. Children whose CCS care will be transitioning under WCM to CalOptima on July 1, 2019, are referred to as Transitioning WCM members.
  Activities: CalOptima identifies children with potentially eligible CCS conditions. Upon confirmation of CCS Program eligibility, CalOptima assigns a Personal Care Coordinator (PCC) to each Member. The PCC assists the members and family to navigate the health care system, accessing high quality primary care providers, CCS-paneled specialists, care centers and Medical Therapy Units. The primary goal is facilitation of timely, appropriate health care and coordination among the health care team, especially including the member and family.

➢ **Health Home Program (HHP) — Improve clinical outcomes of members with multiple chronic conditions and experiencing homelessness**
- **Goal:** Establishing baseline measures in 2019
  - Member Engagement Rate
  - Inpatient Readmissions
  - Emergency Department (ED) Visits
- **Target Population:** DHCS identified list of *highest risk 3-5 % of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria:*
  - Specific combination of physical chronic conditions and/or substance use disorder (SUD) or specific serious mental illness (SMI) condition;
  - Meet specified acuity/complex criteria

- Eligible members consent to participate and receive Health Home Program services.

- **Description of Programs or Services:** A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- **Activities:** Core services as defined by DHCS are detailed below.
  - Comprehensive care management
  - Health promotion
  - Care coordination
  - Individual and family support services
  - Comprehensive transitional care
  - Referral to community and social support services
  - Other new services
    - Accompany participants to critical appointments
    - Provider housing navigation services for members experiencing homelessness
    - Manage transition from non-hospital or nursing facility settings, such as residential treatment programs
    - Trauma informed care

❖ **PHM Activities and Resources [PHM 1A Factor 3]**

➢ CalOptima will use our annual population assessment to review and update our PHM structure, activities and resources. The annual population assessment helps CalOptima to set new program priorities, re-calibrate existing programs, re-distribute resources to ensure health equity, and proactively mitigate emerging risk, such as partnering with Orange County Health Care Agency to address social determinants that adversely impacting the health and wellness of the CalOptima member population and relevant sub-populations.

➢ As the various health care sectors adopt technology to address the changing demographic of the population and bring needed care to members in non-traditional ways, CalOptima will be exploring the feasibility of advancing our mission to provide members with access to quality health care services leveraging advanced virtual technology. In order to bring timely care and services to a broader population, CalOptima will explore the feasibility of leveraging telehealth usage in cases ranging from the traditional e-consult, remote patient monitoring, and texting applications, to non-medical virtual visits in members' homes.

❖ **Expanding Strategies to Inform Members Leveraging Technology [PHM1 A5, PHM B]**

➢ CalOptima deploys multiple methods for informing members about PHM programs and services. Based on the members' language preferences, members

are informed of various health promotion programs, and how to contact Care Management, via the initial Member Packet in the mail, CalOptima website, personal telephone outreach or Robo calls, in person, and by email. One of the PHM strategies to support members age 19–40 is to develop telehealth technology enhanced methods of informing members, such as text or other mobile applications.

- CalOptima PHM programs are accessible to eligible Orange County Medi-Cal beneficiaries who meet the PHM program criteria.
- CalOptima provides instruction on how to use these services in multiple languages and at appropriate health literacy levels.
- CalOptima honors member choice; hence, all the PHM programs are voluntary. The members can decline the program or opt out any time.

❖ **Delivery System for Practitioner/Provider Support [PHM3 A]**

- **Information Sharing**
  - CalOptima Provider Relations and QI departments provide ongoing support to practitioners and providers in our health networks, such as sharing patient-specific data, offering evidenced-based or certified decision-making aids and continuing education sessions, and providing comparative quality and cost information. CalOptima will continue to improve information sharing with Health Network providers using integrated and actionable data.
- **Practice Transformation Technical Assistance (New Idea)**
  - One of the PHM strategies is to offer practice transformation support through Lean QI training, practice site facilitations and/or individualized technical assistance to improve member experience.
- **Provider Coaching and Leadership Development (New Idea)**
  - Offer individual provider coaching sessions and office staff workshops to improve quality of services and patient experience, especially targeting high volume practices and the top 30 providers with high volume grievances and potential quality of services issues.
  - Allocate one scholarship to sponsor community clinic physician leadership development through the California Health Care Foundation (CHCF) Health Care Leaders Fellowship.
- **Pay for Value [PHM3 B]**
  - CalOptima already incentivizes providers based on quality performance in its directly contracted CalOptima Community Network (CCN) and the contracted Health Networks.

❖ **Population Health Management Impact [PMH 6]**

- **Measuring Effectiveness**
  - CalOptima annually conducts a comprehensive analysis of the PHM strategy's impact and effectiveness as part of the annual QI Program evaluation. The comprehensive analysis includes quantitative results for relevant clinical, cost, utilization, and qualitative member experience.

CalOptima regularly compares its performance results with external benchmarks and internal goals. The results are reviewed and interpreted by the interdisciplinary team through various QI Committees. Given the capability of Tableau, an enterprise analytic platform, CalOptima has the capability to conduct longitudinal QI Program Evaluation to ensure sustained effectiveness year over year.

- **Improvement and Action**

- Based on the annual PHM program evaluation using internal and external data, CalOptima annually updates its QI Work Plan to improve CalOptima's PHM program and act on at least one opportunity for improvement within each of the quality domains as define in the CalOptima Quality Improvement Program.

***APPENDICES**:*

2018 NCQA PHM Standards

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Overview

Notable Changes for 2018

Changes to the Policies and Procedures

- ***Section 1***
  - Clarified that a Medicaid-only organization that manages CHIP members included those members in its Medicaid product line.
  - Described how to navigate NCQA's web-based application process.
  - Clarified, under "Organization Obligations," that a Discretionary Survey is based on the standards in effect during the discretionary survey.
- ***Section 2***
  - Added reference to government requirements under "State and Federal Agency Surveys."
  - Added URL for NCQA Guidelines for Advertising and Marketing (http://www.ncqa.org/marketing.aspx) under "Marketing accreditation results"
  - Added PHM 1, Element A to the list of elements with critical factors.
- ***Section 3:***
  - Added "Web-based survey platform" subhead and text.
  - Replaced QI 5 with PHM 4 under "File review results."
- ***Section 4***

  Added a note about Federal Medicaid Rule: §438.332 regarding state deeming survey results.
- ***Section 5***
  - Updated English-speaking USA and Canada fraud hotline number to 844-440-0077.
  - Updated language under "Notifying NCQA of Reportable Events" subhead and added "Annual Attestation of Compliance With Reportable Events" and "NCQA Investigation" subheads and text.
  - Updated language under "Mergers and Acquisitions and Changes to Operations" subhead.
- ***Section 6***
  - Described how to navigate NCQA's Web-based application process.

Changes to the standards and guidelines

- New category, Population Health Management (PHM):
  - *PHM 1: PHM Strategy.*
  - *PHM 2: Population Identification.*
  - *PHM 3: Delivery System Supports.*
  - *PHM 4: Wellness and Prevention.*
  - *PHM 5: Complex Case Management.*
  - *PHM 6: Population Health Management Impact.*
- Moved the following standards to the PHM category:
  - *QI 5: Complex Case Management (PHM 5).*
  - *MEM 1: Health Appraisals (PHM 4,* Elements A–G).
  - *MEM 2: Self-Management Tools (PHM 4,* Elements H–K).

- Eliminated the following standards and elements:
  - *QI 5:*
    - Element B: Complex Case Management Program Description.
    - Element C: Identifying Members for Case Management.
    - Element J: Measuring Effectiveness.
  - *QI 6: Disease Management.*
  - *QI 7: Practice Guidelines.*
  - *MEM 7: Support for Healthy Living.*
  - *UM 4,* Element H: Appropriate Classification of Denials.
- Added a factor to NET 3, Element A: Assessment of Member Experience Accessing the Network.
- Renumbered the QI and MEM standards to account for standards and elements that were incorporated into the PHM category or eliminated.

Changes to the appendices

- ***Appendix 1***
  - Updated points for all evaluation options to account for new PHM category and eliminated QI standards, UM 4, Element H and MEM standards.
- ***Appendix 2***
  - Added new measures for the commercial, Medicare and Medicaid product lines. Refer to the table below.

Measure		Commercial	Medicare	Medicaid
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	✓
IET	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment—*Initiation of AOD Treatment rate*	✓	✓	✓
PSA	Non-Recommended PSA-Based Screening in Older Men	NA	✓	NA
EDU	Emergency Department Utilization	✓	✓	NA
SPC	Statin Therapy for Patients With Cardiovascular Disease—*Both rates*	✓	✓	✓
SPD	Statin Therapy for Patients With Diabetes—*Both rates*	✓	✓	✓
IMA	Immunizations for Adolescents (Combination 2)	✓	NA	✓

  - Retired the measures listed in the table below.

Measure		Commercial	Medicare	Medicaid
ABA	Adult BMI Assessment	Retain	✓	Retain
CDC	Comprehensive Diabetes Care—*Medical Attention for Nephropathy rate*	✓	✓	✓
	Comprehensive Diabetes Care—*HbA1c Poor Control (>9%) rate*	✓	✓	✓
MSC	Medical Assistance With Smoking and Tobacco Use Cessation —*Advising Smokers to Quit rate*	✓	Retain	Retain
IMA	Immunizations for Adolescents (Combination 1)	✓	NA	✓

- ***Appendix 3***
  - Updated points reporting category based on changes in appendix 1.

- ***Appendix 4***
  - Updated calculation of HEDIS score based on changes in appendix 2
- ***Appendix 5***
  - Updated standards and elements eligible for automatic credit based on the new PHM category and eliminated QI requirements. (Refer to *Appendix 5* for the list of changes.)

Accreditation: A Symbol of Quality and Improvement

Why NCQA?

Health plans accredited by NCQA demonstrate their commitment to delivering high-quality care through one of the most comprehensive evaluations in the industry, and the only assessment that bases results on clinical performance (i.e., HEDIS measures) and consumer experience (i.e., CAHPS measures). NCQA publicly reports quality results, allowing "apples-to-apples" comparison among plans. NCQA's Health Plan Accreditation program helps organizations demonstrate their commitment to quality and accountability.

Health plans choose NCQA Health Plan Accreditation because:

- **Employers want it.** Many employers—especially the Fortune 500 employers—do business only with NCQA-Accredited plans. They and other purchasers want to keep employees healthy and productive and maximize the value of their health investment by focusing on quality care. The National Business Coalition on Health's widely used eValue8 tool captures NCQA Accreditation status and HEDIS/CAHPS scores as an important indicator of a plan's ability to improve health, and health care.
- **It meets regulatory requirements.** NCQA Accreditation contains many of the key elements that federal law and regulations require for State Health Insurance and Marketplace plans. Forty-two states recognize NCQA Accreditation as meeting their requirements for Medicaid or commercial plans; 17 states mandate it for Medicaid. The Federal Employees Health Benefit Program accepts NCQA Accreditation.
- **Consumers are looking for quality.** As consumers become more responsible for managing their health care, consumer interest in choosing high-quality plans will grow. The standards focus on key patient protections that consumers, regulators, public purchasers and employers value.
- **It's flexible and comprehensive.** NCQA builds flexible, yet rigorous standards that apply to all types of health plans. Annual updates to accreditation standards support the fast-changing needs of regulators and the health care marketplace. NCQA's Health Plan Accreditation is the most widely recognized accreditation program in the United States.

The rigor and competitive pricing of NCQA's program represent an excellent value for health plans. NCQA supports the accreditation process through its publications, users' groups and educational programs, making the path to performance-based accreditation accessible and feasible.

Changes and Updates: *What's New in 2018?*

NCQA continuously assesses the health care landscape, as well as new and pending regulations, to enhance accreditation standards on an annual basis. The HPA 2018 focuses on a new category*:* Population Health Management (PHM).

New PHM Category: NCQA combined existing population health management related requirements from Health Plan Accreditation categories (Quality Management and Improvement [QI] and Member Connections [MEM]) and new requirements that reflect a broader, population-wide focus on care management. The update removes elements that no longer add value.

- ***Reasons for the update:*** NCQA's goal is to streamline evaluation of an organization's population health management strategy by consolidating PHM-related elements into one category. The new category provides flexibility in how plans manage their members and encourages health plans to work with the delivery system to deliver quality care.

Tracking Out-of-Network Requests: A new factor (3) in NET 3A: Assessment of Member Experience Accessing the Network expands tracking of out-of-network requests for services to all product lines.

- ***Reasons for the update:*** Network adequacy is an important area of concern for consumers and purchasers alike because it affects timely access to care and out-of-pocket costs among other areas. The intent of this requirement is that organizations monitor and identify issues of access to primary care services, behavioral healthcare services and other specialty services. Analysis of out-of-network data helps organizations understand why members seek out-of-network services. Finding ways to address these occurrences can lead to better member experience.

Marketplace Readiness

NCQA's Health Plan Accreditation is the superior choice for insurers offering Marketplace products. It provides a "glide path" to accreditation; plans with varied goals and capabilities can earn the NCQA seal. The glide path involves three options or steps:

1. **Interim Evaluation** is for organizations that need accreditation before or soon after they open for business. It focuses on insurers' policies and procedures, does not include HEDIS/CAHPS reporting.
2. **First Evaluation** is for organizations new to NCQA. HEDIS/CAHPS reporting is required only in the final year, helping plans prepare for their Renewal Evaluation.
3. **Renewal Evaluation** is available to NCQA-Accredited organizations seeking to extend their accreditation. HEDIS/CAHPS reporting is mandatory, and performance results count in the scoring.

Accreditation Scoring System

NCQA uses the standards and audited HEDIS/CAHPS results to evaluate an organization. Depending on the Evaluation Option selected, a total of 50 or 100 points is possible (i.e., performance against the standards accounts for 50 possible points; HEDIS results account for 50 possible points).

Organizations submit audited results for designated HEDIS measures for each product line/product brought forward for accreditation as required for the Evaluation Option selected. To ensure validity, accuracy and comparability, an NCQA-Certified HEDIS Compliance Auditor must audit the results. NCQA evaluates the organization's audited HEDIS results against established benchmarks and thresholds to determine the score.

Accreditation Status Levels

Because most organizations offer several product lines (i.e., commercial, Marketplace, Medicare, Medicaid), NCQA determines accreditation status by product line for HMO, POS PPO and EPO products. Each product line/product reviewed by NCQA earns one of the following accreditation status levels, based on evaluation of the organization's performance against the standards and HEDIS results (if applicable) and the Evaluation Option.

- Excellent.
- Commendable.
- Accredited.
- Provisional.
- Interim.
- Denied.

New: PHM Category of Standards

Health care expenditures account for 17 percent of the gross domestic product ($17 trillion) in the United States, estimated to be 20 percent by 2020.[3] Although health spending is the highest in the world, our life expectancy is significantly shorter than that of other industrialized nations. Guided by the Institute for Healthcare Improvement's (IHI) Triple Aim framework,[4] the federal government, states, health plans and other stakeholders are tackling these challenges through various initiatives. The Triple Aim framework has three main objectives: improve patient experience of care, improve the health of populations and reduce the per capita cost of health care.

NCQA emphasizes the Triple Aim throughout Health Plan Accreditation through its new standard category, Population Health Management (PHM). PHM addresses health at all points on the continuum of care, including the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions.[5]

This category's scope facilitates population health management, not public health—an important distinction. "Public health" is a broad term for the coordinated efforts of local, state and national health departments to improve the quality of health for insured and uninsured community members. "Population health management" supports care activities for a defined population.

The PHM standards establish basic expectations:

1. Organizations have a population health management strategy that focuses on the "whole person" and the member's entire care journey.
2. Organizations can provide wellness services (e.g., health appraisal administration, self-management tools) and intervene with highest-risk members (i.e., requiring complex case management).
3. Organizations have the flexibility to choose members/populations with which to intervene (including the specific population under complex case management).
4. Organizations are committed to supporting their delivery system to facilitate better health outcomes and encourage value-based decisions.

The PHM requirements were developed through literature reviews, Stakeholder Advisory Committee discussions, feedback from our public comment period and enhanced feedback from additional stakeholder advisory councils and groups.

Delivery System Support and Value-Based Payment Arrangements

NCQA recognizes the need to align organizations with the delivery system, including hospitals, accountable care entities, practitioners and PCMHs, and other vendors delivering care. Toward that end, NCQA recommends standards for delivery system supports, with elements that allow flexibility in how organizations support delivery system. The elements provide many methods to support providers and allow the health plans to determine which best fit their network arrangement and current delivery system capabilities. Through these requirements, NCQA intends to increase data sharing and transparency between plans and providers. Also, NCQA requires a report describing the organization's value-based payment arrangements to better understand the changing landscape of the healthcare market *(PHM 3: Delivery System Supports)*.

[3]CMS Strategy: The Road Forward 2013-2017. https://www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf
[4]IMI Triple Aim Initiative. http://www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx
[5]Population Health Alliance. http://www.populationhealthalliance.org/research/understanding-population-health.html

Eliminated Elements

NCQA eliminated the following standards and elements. With these changes, the HPA focus shifts from single-condition evaluation to population health-based evaluation. Retired elements include:

- ***QI 5:***
  - Element B: Complex Case Management Program Description.
  - Element C: Identifying Members for Case Management.
  - Element J: Measuring Effectiveness.
  - Element K: Action and Remeasurement.
- ***QI 6:***
  - Element A: Program Content.
  - Element B: Identifying Members for DM Programs.
  - Element C: Frequency of Member Identification.
  - Element E: Interventions Based on Assessment.
  - Element F: Eligible Member Active Participation.
  - Element G: Informing and Educating Practitioners.
  - Element H: Integrating Member Information.
  - Element I: Experience With Disease Management.
  - Element J: Measuring Effectiveness.
- ***QI 7:***
  - Element A: Adoption of Guidelines.
  - Element B: Adoption of Preventive Health Guidelines.
  - Element C: Relation to DM Programs.
  - Element D: Performance Measurement.
- ***MEM 7:***
  - Element A: Identifying Members.
  - Element B: Targeted Follow-Up With Members.

Where to Find Specific Information

The *Standards and Guidelines* include policies and procedures, standards and elements, scoring guidelines and appendices.

Policies and Procedures

- Information on organizations eligible for accreditation.
- Responsibilities of organizations seeking accreditation.
- Information on applying for accreditation.
- Information on the survey tool and readiness evaluation.
- Information on reporting accreditation results.
- Information on annual reevaluation.
- Information on the Accreditation Survey process.
- Information on evaluating HEDIS results and calculating HEDIS scores.
- Information on the Reconsideration process.

Accreditation Standards, Organized by Category

- The standards, elements and factors.
- A summary of changes from the previous standards year.
- Scoring guidelines describing requirements for each standard, element and factor.
- Information about how an organization can demonstrate performance against the element's requirements.
- Data sources for demonstrating compliance with requirements.
- The scope of review.
- The look-back period.

Appendices

- Appendix 1: Standard and Element Points for 2018.
- Appendix 2: HEDIS and CAHPS Points for HEDIS Reporting Year 2018.
- Appendix 3: Points by Reporting Category for 2018.
- Appendix 4: Calculating the Total HEDIS Score.
- Appendix 5: Delegation and Automatic Credit Guidelines.
- Appendix 6: CMS Regions.
- Appendix 7: Merger, Acquisition and Consolidation Policy for Health Plan Accreditation and LTSS Distinction.
- Appendix 8: Answers to Commonly Asked Questions.
- Appendix 9: Glossary.
- Appendix 10: Summary of Changes for 2018.

Other Important NCQA Information

NCQA publications, user groups and educational programs facilitate the evaluation process. They help plans succeed by making the path to performance-based accreditation accessible and feasible. In addition to the web-based survey platform, NCQA provides a variety of information to help organizations prepare for Accreditation Surveys.

- NCQA produces many publications relevant to organizations. Call NCQA Customer Support at 888-275-7585 or go to the NCQA website (www.ncqa.org).
- Access policy clarifications from the NCQA Policy Clarification Support (PCS) system on the NCQA Web page (http://my.ncqa.org). General questions are usually answered within 2 business days; complex questions are usually answered within 30 days.
- Find corrections, clarifications and policy changes to this publication at http://www.ncqa.org/tabid/119/Default.aspx/
- Find frequently asked questions (FAQ) at http://ncqa.force.com/faq/FAQSearch FAQs are updated on the 15th of the month or on the first business day following the 15th of the month.
- Organizations that are involved in NCQA Accreditation and Certification activities are encouraged to join the Accreditation and Certification Users Group (ACUG). The ACUG provides a learning and development platform for members to discuss updates applicable to their organization's procedures. Membership benefits include a monthly newsletter; WebEx discussions; and vouchers for publications, educational conferences and Quality Compass. For more information, e-mail acug@ncqa.org or go to http://www.ncqa.org/programs/accreditation/accreditation-certification-users-group-acug for a full description of the program.

- Organizations collecting HEDIS data are encouraged to join the NCQA HEDIS Users Group (HUG) for technical assistance and guidance on interpreting measure specifications. Membership benefits include NCQA HEDIS and accreditation publications, newsletters, Internet seminars, discount vouchers for HEDIS conferences and publications and up-to-date technical information. For more information, e-mail hug@ncqa.org.
- NCQA educational seminars provide valuable information on NCQA standards, the survey process and HEDIS. Course offerings range from a basic introduction to NCQA standards and HEDIS measures to advanced techniques for quality improvement. Visit the NCQA website or call NCQA Customer Support at 888-275-7585.
- NCQA staff are available to help organizations determine the Evaluation Option for which they are eligible. Staff provide step-by-step guidance on the application process, which includes an overview of policies and procedures, the fee structure, timelines and survey preparation. Contact ApplicationsandScheduling@ncqa.org.

Other NCQA Programs

NCQA offers the following accreditation programs:

- Accountable Care Organization (ACO).
- Case Management (CM).
- Case Management for Long-Term Services and Supports Programs (CM-LTSS).
- Disease Management (DM).
- Managed Behavioral Healthcare Organization (MBHO).
- Wellness and Health Promotion (WHP).

NCQA offers the following certification programs:

- Accreditation in Utilization Management, Credentialing and Provider Network UM/CR/PN).
- Credentials Verification Organization (CVO).
- Disease Management (DM).
- Health Information Products (HIP).
- Physician and Hospital Quality (PHQ).
- Wellness and Health Promotion (WHP).

NCQA offers the following recognition programs:

- Diabetes Recognition (DRP).
- Heart/Stroke Recognition (HSRP).
- Patient-Centered Connected Care™
- Patient-Centered Medical Home (PCMH).
- Patient-Centered Specialty Practice (PCSP).
- Oncology Medical Home (PCMH-O).
- School-Based Medical Home (SBMH).

NCQA offers the following evaluation program:

- New York Ratings Examiner Reviews (NYRx).

NCQA offers the following distinction programs:

- Multicultural Health Care (MHC).
- Long-Term Services and Supports (LTSS).

NCQA offers the following distinction programs for recognized PCMHs:

- Patient Experience Reporting.
- Behavioral Health Integration.
- Electronic Quality Measures (eCQM) Reporting.

Note: *Organizations that contract with NCQA-Accredited or NCQA-Certified organizations can reduce their delegation oversight. Refer to* Appendix 5: Delegation and Automatic Credit Guidelines*.*

11/20/17: Add the following as the last bullet under "NCQA offers the following accreditation programs":
• Utilization Management, Credentialing and Provider Network (UM-CR-PN).
• Delete the first bullet under "NCQA offers the following certification programs" that reads:
• Accreditation in Utilization Management, Credentialing and Provider Network (UM-CR-PN).

Population Health Management

Standards for Population Health Management

PHM 1: PHM Strategy—*Refer to Appendix 1 for points*

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Additions

- Added *PHM 1, Element A: Strategy Description* as a new element.

Clarifications

- Added "interactive contact" to the element stem (Element B).
- Updated the scope of review to state that NCQA reviews up to 4 randomly selected programs (Element B).
- Added language to address how the element will be reviewed for the 2019 Standards Year (Element B).

Element A: Strategy Description—*Refer to Appendix 1 for points*

The strategy describes:

1. **Goals and populations targeted for each of the four areas of focus.***
2. **Programs or services offered to members.**
3. **Activities that are not direct member interventions.**
4. **How member programs are coordinated.**
5. **How members are informed about available PHM programs.**

Critical factors: Score cannot exceed 20% if critical factors are not met.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a description of the organization's comprehensive PHM strategy. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.

For First and Renewal Surveys: 6 months.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

Factor 1 is a **critical factor** that the organization must meet to score higher than 20% on this element.

The organization has a comprehensive strategy for population health management that *at minimum* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

***Factors 1, 2:* Four areas of focus**

At a minimum, the description includes for each of the four areas of focus:

- Goals (factor 1).
- Populations targeted (factor 1).
- Program or services for each area of focus (factor 2).

Goals are measurable and connected to a targeted population. NCQA does not prescribe a definition of "program or services." Programs and services may be provided to members by the organization or by other entities.

***Factor 3:* Activities that are not direct member interventions**

The organization describes all activities conducted by the organization that support PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

***Factor 4:* Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across potential settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

***Factor 5:* Informing members**

The organization describes its methods for informing members about all available PHM programs and services. Programs and services include any level of contact. The organization may make the information available on its website; by mail, e-mail, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

- Goal: 55 percent of members in the targeted population report receiving annual influenza vaccinations.
  - Targeted populations:
    - Members with no risk factors.
    - Members enrolled in wellness programs.

  - Programs or services: Community flu clinics, e-mail and mail reminders, radio and TV advertisement reminding public to receive vaccine.
- Goal: 10 percent of targeted population reports meeting self-determined weight-loss goal.
  - Targeted population: Members with BMI 27 or above enrolled in wellness program.
  - Programs or services: Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  - Targeted population:
    - Members discovered at risk for diabetes during predictive analysis.
    - Members with controlled diabetes.
  - Programs or services: Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  - Targeted population: Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  - Programs or services: Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
  - Targeted population: Members who are prescribed high-alert medications and receive home health care.
  - Activity: Collaborate with community-based organizations to complete medication reconciliation during home visits.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of three days or more by 2 percentage points compared to baseline.
  - Targeted population: Members admitted through the emergency department who remain in the hospital for three days or more.
  - Program or services: Organization-based case manager conducts follow-up interview post-stay to coordinate needed care.
  - Activity: Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  - Targeted population: Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  - Programs or services: Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  - Targeted population: Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  - Programs or services: Complex case management with behavioral health telehealth counseling component.

Factor 3: **Activities that are not direct member interventions**

- Data and information sharing with practitioners.
- Interactions and integration with delivery systems (e.g., contracting with accountable care organizations).
- Providing technology support to or integrating with patient-centered medical homes.

- Integrating with community resources.
- Value-based payment arrangements.
- Collaborating with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborating with hospitals to improve patient safety.

Element B: Informing Members——*Refer to Appendix 1 for points*

The organization informs members eligible for programs that include interactive contact:

1. **How members become eligible to participate.**
2. **How to use program services.**
3. **How to opt in or opt out of the program.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: For surveys beginning on or after July 1, 2019, NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: 6 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure e-mail.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or e-mail, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, e-mail, telephone, mobile device or Internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care. To contact the nurse directly, call 555-555-1234.

If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—*Refer to Appendix 1 for points*

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Additions

- Added *PHM 2, Element A: Data Integration* as a new element.
- Added *PHM 2, Element D: Segmentation* as a new element.
- Split factor 1 into two factors, factors 1 and 2, updated scoring and added social determinants of health to factor 1 language (Element B).
- Added a new factor 3: "Review community resources for integration into program offerings to address member needs" (Element C).

Clarifications

- Updated the scope of review for First Surveys and Renewal Surveys to state "at least once during the prior year" (Element B).
- Updated the explanation to reflect population health management (Elements B, C).
- Updated the look-back period for all surveys to state "prior to the survey date" (Element C).

Element A: Data Integration—*Refer to Appendix 1 for points*

The organization integrates the following data to use for population health management functions:

1. **Medical and behavioral claims or encounters.**
2. **Pharmacy claims.**
3. **Laboratory results.**
4. **Health appraisal results.**
5. **Electronic health records.**
6. **Health services programs within the organization.**
7. **Advanced data sources.**

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For Interim Surveys: NCQA reviews the organization's policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim, First and Renewal Surveys: Prior to the survey date.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results would not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources are those that aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges or other community collaboratives. The organization must have access to use data from the source to meet the intent.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
  - Health information line.

Advanced data sources may require two-way data transfer: The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to**:**

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—*Refer to Appendix 1 for points*

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

Factor 1: **Characteristics and needs**

The organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, social determinants of health must be assessed. **Social determinants of health**[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

Factor 2: **Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

Factor 3: **Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

Factors 4, 5: **Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for Medicare.

Examples

Factors 1, 2: **Relevant characteristics**

Social determinants of health include:

- Resources to meet daily needs.
- Safe housing.
- Local food markets.
- Access to educational, economic and job opportunities.
- Access to health care services.
- Quality of education and job training.
- Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
- Transportation options.
- Public safety.
- Social support.
- Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
- Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
- Socioeconomic conditions.
- Residential segregation.
- Language/literacy.
- Access to mass media and emerging technologies.
- Culture.

Physical determinants include:

- Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
- Built environment, such as buildings, sidewalks, bike lanes and roads.
- Worksites, schools and recreational settings.
- Housing and community design.
- Exposure to toxic substances and other physical hazards.
- Physical barriers, especially for people with disabilities.
- Aesthetic elements (e.g., good lighting, trees, and benches).
- Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
- Nature and extent of carved out benefits.
- Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
- Race/ethnicity and language preference.

Element C: Activities and Resources——*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period *For Interim Surveys, First Surveys, and Renewal Surveys:* Prior to the survey date.

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.
- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—*Refer to Appendix 1 for points*

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's reports demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of

targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high risk pregnancy, multiple inpatient admissions). Organizations may use various risk stratification methods or approaches to determine actionable subsets.

Segmentation and stratification methods use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs/services members are eligible for. Methods may also include utilization/resource use or cost information, but methods that use only cost information to determine categories do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during the look back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may not add to 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management. Reports must reflect the number of members eligible for each PHM program.

Examples

***Health Plan A:* Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

***Health Plan A:* Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
No risk factors	Routine member newsletters	6,000	15%
No associated data	None	4,800	12%

PHM 3: Delivery System Supports—*Refer to Appendix 1 for points*

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Additions

- Added *PHM 3: Delivery System Supports* as a new standard.

Element A: Practitioner or Provider Support—*Refer to Appendix 1 for points*

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. **Sharing data.**
2. **Offering certified shared-decision making aids.**
3. **Providing practice transformation support to primary care practitioners.**
4. **Providing comparative quality information on selected specialties.**
5. **Providing comparative pricing information for selected services.**
6. **One additional activity to support practitioners or providers in achieving PHM goals.**

Scoring

100%	80%	50%	20%	0%
The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For *Interim Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the organization's description of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and *Renewal Surveys*: 6 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers with which they support.

***Factor 1:* Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

***Factor 2:* Certified shared-decision making aids.**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

The organization provides information (e.g., through the organization, practitioner, provider) about how, when, what conditions, and to whom certified SDM aids are offered. SDM aids must be certified by a third-party entity that evaluates quality. At least one SDM aid must be certified to meet the intent.

***Factor 3:* Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

***Factor 4:* Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

***Factor 5:* Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization can receive automatic credit for factors 3 and 6 if the organization is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Examples

Factor 1

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
  - Claims data.
  - Data generated by specialists, urgent clinics or other care providers.
- Methods of data sharing:
  - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
- Reports created for practitioners or providers about patients or the attributed population.
  - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.

Factor 2

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 3

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Factor 4

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
  - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS measures.
    - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
    - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—*Refer to Appendix 1 for points*

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring

100%	80%	50%	20%	0%
The organization demonstrates it has VBP arrangement(s) by reporting the percentage of payment tied to VBP	No scoring option	No scoring option	No scoring option	The organization does not demonstrate that it has VBP arrangement(s)

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For *First Surveys* and *Renewal Surveys*, NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.

The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and *Renewal Surveys*: Prior to the survey date.

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The FFS model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS* Reports *to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- **Pay-for-performance (P4P):** Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- **Shared savings:** Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- **Shared risk:** Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- **Two-sided risk sharing:** Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- **Capitation/population-based payment:** Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- (Numerator:) Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- (Denominator:) Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples

None.

PHM 4: Wellness and Prevention—*Refer to Appendix 1 for points*

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Additions

- Added factor 14 (Safety behaviors), added explanation text and updated the 100% scoring to reflect the new factor (Element C).

Clarifications

- Revised standard stem and intent statement.
- Added an exception for the Medicaid product line (Elements A–G).
- Clarified the explanation under the subhead for *Factor 5: Special needs assessment* to state that questions include specific demographics to meet the requirement (Element A).
- Clarified the explanation under the subhead for factor 2 to include requirements for the HA disclosure (Element B).

Element A: Health Appraisal Components—*Refer to Appendix 1 for points*

The organization's HA includes the following information:

1. **Questions on demographics.**
2. **Questions on health history, including chronic illness and current treatment.**
3. **Questions on self-perceived health status.**
4. **Questions to identify effective behavioral change strategies.**
5. **Questions to identify members with special hearing and vision needs and language preference.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.

The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.

***Factor 1:* Demographics**

Member demographics include age, gender and ethnicity.

***Factor 2:* Personal health history**

No additional explanation required.

***Factor 3:* Self-perceived health status**

Self-perceived health status is a members' assessment of current health status and well-being.

***Factor 4:* Behavioral change strategies**

The HA includes questions to help guide changes in behavior and reduce risk.

***Factor 5:* Special needs assessment**

The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 1:* Demographics**

- Age.
- Gender.
- Race or ethnicity.
- Level of education.
- Level of income.
- Marital status.
- Number of children.

Factor 2: **Personal health history**

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

Factor 3: **Self-perceived health status**

- SF 20® questions or other questions where participants rate their health status on a relative scale.

Factor 4: **Behavioral change theories and models**

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

Factor 5: **Special needs assessment**

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—*Refer to Appendix 1 for points*

The organization's HA includes the following information in easy-to-understand language:

1. **How the information obtained from the HA will be used.**
2. **A list of organizations and individuals who might receive the information, and why.**
3. **A statement that participants may consent or decline to have information used and disclosed.**
4. **How the organization assesses member understanding of the language used to meet factors 1–3.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Use of HA information**

No additional explanation required.

***Factor 2:* Information recipients**

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

***Factor 3:* Right to consent or decline**

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

***Factor 4:* Assessing member understanding**

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 2:* Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—*Refer to Appendix 1 for points*

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. **Weight.**
2. **Height.**
3. **Smoking and tobacco use.**
4. **Physical activity.**
5. **Healthy eating.**
6. **Stress.**
7. **Productivity or absenteeism.**
8. **Breast cancer screening.**
9. **Colorectal cancer screening.**
10. **Cervical cancer screening.**
11. **Influenza vaccination.**
12. **At-risk drinking.**
13. **Depressive symptoms.**
14. **Safety behaviors.**

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

***Factor 14:* Safety behaviors**

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

***Factor 7:* Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—*Refer to Appendix 1 for points*

Participants receive their HA results, which include the following information in language that is easy to understand:

1. **An overall summary of the participant's risk or wellness profile.**
2. **A clinical summary report describing individual risk factors.**
3. **Information on how to reduce risk by changing specific health behaviors.**
4. **Reference information that can help the participant understand the HA results.**
5. **A comparison to the individual's previous results, if applicable.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot

provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

***Factor 1:* Overall summary of risk and wellness profile**

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

***Factor 2:* Clinical summary report**

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

***Factor 3:* Reducing risk and changing behavior**

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

***Factor 4:* Reference information**

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

***Factor 5:* Comparing HA results**

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element E: Health Appraisal Format—*Refer to Appendix 1 for points*

The organization makes HAs available in language that is easy to understand, in the following formats:

1. **Digital services.**
2. **In print or by telephone.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA, and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy to understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Digital services**

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples None.

Element F: Frequency of Health Appraisal Completion—*Refer to Appendix 1 for points*

The organization has the capability to administer the HA annually.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

Evidence of capability to administer

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process —*Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys, NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation and evaluates the vendor's HA against the requirements.

Examples

Evidence of review

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—*Refer to Appendix 1 for points*

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—*Refer to Appendix 1 for points*

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. **Language is easy to understand.**
2. **Members' special needs, including vision and hearing, are addressed.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation

Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs and the organization assesses its tools for members who have vision or hearing limitations. All must be addressed in order to receive credit for this factor.

Exception

Factors marked "No" in Element A are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

Guidelines on usability testing for online tools

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools
—Refer to Appendix 1 for points

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. **Healthy weight (BMI) maintenance.**
2. **Smoking and tobacco use cessation.**
3. **Encouraging physical activity.**
4. **Healthy eating.**
5. **Managing stress.**
6. **Avoiding at-risk drinking.**
7. **Identifying depressive symptoms.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For Renewal Surveys, NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

Factors 1–7

No explanation required.

Exception

Factors marked "No" in Element A are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

None.

Element K: Self-Management Tool Formats—*Refer to Appendix 1 for points*

The organization's self-management tools are offered in the following formats for each required seven health areas:

1. **Digital services.**
2. **In print or by telephone.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The content of self-management tools is the same in all formats.

***Factor 1:* Digital services**

Digital services include online, Internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation and evaluates the vendor's self-management tools against the requirements.

Examples

None.

PHM 5: Complex Case Management—*Refer to Appendix 1 for points*

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Additions

- Combined former factor 1 (Health information line referral), factor 2 (DM program referral), factor 4 (UM referral) to the new factor 1 (Medical management program referral), updated scoring and added Explanation text for that factor (Element A).

Clarifications

- Clarified the standard statement to specify that highest-risk members are included in the CCM program.
- Replaced “psychosocial issues” with “social determinants of health” in factor 5 and revised the explanation text for that factor (Element C).
- Clarified the scope of review to state “files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management” (Elements D, E).
- Updated the factor 5 language to state “initial assessment of social determinants of health” and revised the explanation text (Element D).
- Updated timeliness of assessment to state that the organization's initial assessment begins within 30 calendar days of identification and is completed within 60 days of identification (Element D).
- Added a fourth bullet under the subhead *Timeliness of assessment:* “The member is dead” (Element D).
- Added an example: *Factors 1–5: Case Management—Ongoing Management* (Element E).
- Added a bullet under the subhead for *Factor 1: Analyzing member feedback* in the explanation (Element F).

Element A: Access to Case Management—*Refer to Appendix 1 for points*

The organization has multiple avenues for members to be considered for complex case management services, including:

1. **Medical management program referral.**
2. **Discharge planner referral.**
3. **Member or caregiver referral.**
4. **Practitioner referral.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.
- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—*Refer to Appendix 1 for points*

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

***Factor 2:* Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

***Factor 3:* Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples

None.

Element C: Case Management Process—*Refer to Appendix 1 for points*

The organization's complex case management procedures address the following:

1. **Initial assessment of members' health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and follow-up process to determine whether members act on referrals.**

15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source

Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

This is a **structural requirement.** The organization must present its own documentation.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases). The organization records the specific factor and the reason in the case management system and file.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Factor 1: **Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment should includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

Factor 2: **Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

Factor 3: **Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to activities of daily living, such as eating, bathing and mobility.

***Factor 4:* Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

***Factor 5:* Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

***Factor 6:* Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If a member does not have expressed life-planning instructions on record, during the first contact the case manager determines if life-planning instructions are appropriate. If they are not, the case manager records the reason in the member's file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

***Factor 7:* Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. It should include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

***Factor 8:* Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

***Factor 9:* Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

***Factor 10:* Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

***Factor 11:* Evaluation of community resources**

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.

***Factor 12:* Individual case management plan and goals**

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frame for reevaluation of goals.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.
  - Time frames for reevaluation are specified in the case management plan.

***Factor 13:* Identification of barriers**

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

***Factor 14:* Referrals to available resources**

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

***Factor 15:* Follow-up schedule**

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.

- Self-management support.
- Determining when follow-up is not appropriate.

***Factor 16:* Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). **Self-management plans** are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

***Factor 17:* Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

***Factor 3:* Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

***Factor 4:* Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

***Factor 5:* Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.
- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

***Factor 7:* Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

***Factor 9:* Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

***Factor 10:* Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

***Factor 14:* Assessment of barriers[2]**

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

***Factor 16:* Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).
  - Self-administer medication (e.g., oral, inhaled or injectable).
  - Self-administer medical procedures/treatments (e.g., change wound dressing).
  - Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
  - Maintain a prescribed diet.
  - Chart daily weight, blood sugar.

[2]Lorig, K. 2001. *Patient Education, A Practical Approach.* Sage Publications, Thousand Oaks, CA. 186–92.

Element D: Initial Assessment—*Refer to Appendix 1 for points*

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. NCQA scores each factor "No" for files of initial assessments completed 60 calendar days or more from member identification, unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, e-mail or fax.
- Natural disaster.
- The member is dead.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Files excluded from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - E-mail.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

Factor 1: **Initial assessment of members' health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

Factor 2: **Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

Factor 3: **Initial assessment of activities of daily living**

The file or case record documents a case manager's assessment of the member's functional status relative to at least the six basic ADLs. Bathing, hygiene, dressing, toileting, transferring or functional mobility and eating.

Factor 4: **Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Factor 6: **Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.
- Health literacy.

Factor 7: **Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

Factor 8: **Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. The documentation describes what resources are in place, whether these a sufficient for the members needs and notes specific gaps that should be addressed.

Factor 9: **Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of member's specific health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 10: **Evaluation of community resources**

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources. At a minimum, the evaluation includes:

- Community mental health.
- Transportation.
- Wellness programs.
- Nutritional support.
- Palliative care programs.

If a specific resource is not applicable to the member's situation, the case record or file documents why.

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

During the first contact, the case manager assesses and documents whether it is appropriate to discuss these activities and documents with the member. If determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place.

If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples

None.

Element E: Case Management—Ongoing Management—*Refer to Appendix 1 for points*

The NCQA review of a sample of the organization's complex case management files that demonstrates that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

100%	80%	50%	20%	0%
High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Files excluded from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - E-mail.
  - Fax.

- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

***Factor 1:* Case management plans and goals**

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities.

***Factor 2:* Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

***Factor 3:* Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

***Factor 4:* Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

***Factor 5:* Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:*** **Case Management—Ongoing Management**

Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)	
Identification date: 1/5/2017	**Initial Assessment Completed:** 1/30/2017
Goal 1:	Secure stable housing for member by 2/11/2017. **(Factor 1**)
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. **(Factor 1)** *Strategies to achieve goal:* Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services. *Barriers to goal:* Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. **(Factor 2)** *Progress assessment:* Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2017 and investigated group housing. **(Factor 5)**	
Goal 1 completed:	2/16/2017. ***Note:*** *Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings.* **(Factor 5)**
Goal 2:	• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2017) over 3–6 months. • Improve 5 points from baseline by 4/30/2017. • Improve 11 points from baseline by 7/30/2017. **(Factor 1)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)** *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)** *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/2017. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/2017. Score was 12 (11 less than baseline). **(Factor 5)**	
Goal 2 completed:	7/28/2017. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**

Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via [number]. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*: *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* (Factor 4)**

Element F: Experience With Case Management—*Refer to Appendix 1 for points*

At least annually, the organization evaluates experience with its complex case management program by:

1. **Obtaining feedback from members.**
2. **Analyzing member complaints.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For *First Surveys,* NCQA reviews the organization's most recent annual data collection and evaluation report.

For *Renewal Surveys,* NCQA reviews the last two annual data collections and evaluation reports.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Analyzing member feedback**

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: **Analyzing member complaints**

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You…	Very Satisfied		Satisfied		Combined		Sample Size	Percentage of Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan?	75	60	25	20	100	80	125	No
With how the case manager helped you get the care you needed?	80	64	35	28	115	92	125	Yes
With the case manager's attention and help with problems?	70	56	45	36	1151	92	125	Yes
With how the case manager treated you?	85	68	35	28	120	96	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2017	Total 2016
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2018; there were 26 in 2017. Totals by category were also lower in 2018 than in 2017. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact *—Refer to Appendix 1 for points*

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Additions

- Added *PHM 6: Population Health Management Impact* as a new standard.

Element A: Measuring Effectiveness—*Refer to Appendix 1 for points*

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. **Quantitative results for relevant clinical, cost/utilization and experience measures.**
2. **Comparison of results with a benchmark or goal.**
3. **Interpretation of results.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys, NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. Beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: 6 months.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

The organization conducts an annual quantitative analysis of findings.

***Factor 1:* Quantitative results**

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. There are two types of clinical measures:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality).
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization uses complex case management member experience results and member experience results from one other program or service.

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: Comparison of results

The organization performs a first-level, quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Interpretation of results gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The measures must be analyzed and assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. The interpretation of the results should include interpretation of the measures and should go beyond just a presentation of the quantitative results of the measures. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36y to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—*Refer to Appendix 1 for points*

The organization uses results from the PHM impact analysis to annually:

1. **Identify opportunities for improvement.**
2. **Act on one opportunity for improvement.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys, for surveys beginning on or after July 1, 2019, NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: Prior to the survey date.

Explanation

This element is a **structural requirement.** The organization must present its own materials.

***Factor 1:* Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

***Factor 2:* Act on opportunity for improvement**

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

This element is NA for 2018.

Examples

None.

PHM 7: Delegation of PHM—*Refer to Appendix 1 for points*

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Additions

- Added *PHM 7: Delegation of PHM* as a new standard.

Element A: Delegation Agreement—*Refer to Appendix 1 for points*

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element B: Provision of Member Data to the Delegate—*Refer to Appendix 1 for points*

The organization provides the following information to its delegates when requested:

1. **Member experience data, if applicable.**
2. **Clinical performance data.**

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews a sample of up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four. NCQA reviews the organization's process for sharing information with its delegates.

For First Surveys and Renewal Surveys, NCQA also reviews evidence that the organization provides the delegate with direct access to or shared the information with its delegates when requested throughout the look-back period.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation

This element may not be delegated.

If the organization delegates PHM activities, it allows the delegate to collect performance data necessary to assess member experience and clinical performance, as applicable. If the organization does not allow the delegate to collect data from members or practitioners directly, it provides data to the delegate to assess its performance.

NCQA scores this element "Yes" if the organization allows the delegate to collect performance data directly or provides data to the delegate.

***Factor 1:* Member experience data**

The organization provides data from complaints, CAHPS 5.0H survey results and other data collected on members' experience with the delegate's services.

***Factor 2:* Clinical performance data**

The organization provides data to the delegate on HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or provide results of relevant clinical performance measures.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples

None.

Element C: Provisions for PHI—*Refer to Appendix 1 for points*

If the delegation arrangement includes the use of protected health information (PHI) by the delegate, the delegation document also includes the following provisions:

1. **A list of the allowed uses of PHI.**
2. **A description of delegate safeguards to protect the information from inappropriate use or further disclosure.**
3. **A stipulation that the delegate ensures that subdelegates have similar safeguards.**
4. **A stipulation that the delegate provides individuals with access to their PHI.**
5. **A stipulation that the delegate informs the organization if inappropriate use of the information occurs.**
6. **A stipulation that the delegate ensures that PHI is returned, destroyed or protected if the delegation agreement ends.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 4-5 factors	The organization meets 2-3 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect within the look-back period.

***Factor 1:* Allowed uses of PHI**

The delegation agreement specifies PHI the delegate may use and disclose, and to whom PHI may be disclosed.

***Factors 2, 3:* Delegate and subdelegate safeguards**

The organization provides reasonable administrative, technical and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

***Factor 4:* Access to PHI**

No additional explanation required.

***Factor 5:* Inappropriate use of PHI**

The agreement specifies procedures for delegates to identify and report unauthorized access, use, disclosure, modification or destruction of PHI and the systems used to access or store PHI.

***Factor 6:* Disposal of PHI**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements do not involve the use, creation or disclosure of PHI in any form.
- The agreement states that the delegation arrangement does not involve PHI.
- Delegation arrangements are with covered entities.

Examples None.

Element D: Predelegation Evaluation—*Refer to Appendix 1 for points*

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

100%	80%	50%	20%	0%
The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.

For *Renewal Surveys*: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 12 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within the prescribed look-back periods prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the prescribed look-back period, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities less than 6 months or 12 months, as prescribed by the look-back period, prior to the survey date, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaborative. An organization may collaborate in a statewide, predelegation evaluation with other organizations that have overlapping practitioner and provider networks. The organizations in the collaborative use the same audit tool and share data.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element E: Review of PHM Program—*Refer to Appendix 1 for points*

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports

Scope of review

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For *Interim Surveys*, NCQA reviews the organization's review of the delegate's PHM program.

For *First Surveys*, NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 6 months for all other PHM activities.

For *Renewal Surveys*: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 "yes" if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

***Factor 1:* Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

***Factor 2:* Annual file audit**

If the organization delegates complex case management , it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

***Factor 3:* Annual evaluation**

No additional explanation required.

***Factor 4:* Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Examples

None.

Element F: Opportunities for Improvement—*Refer to Appendix 1 for points*

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For *First Surveys*, NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For *Renewal Surveys*, NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 6 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  - NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples

None.

Population Health Management

Standards for Population Health Management

PHM 1: PHM Strategy—*Refer to Appendix 1 for points*

The organization outlines its population health management (PHM) strategy for meeting the care needs of its member population.

Intent

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

Summary of Changes

Clarifications

- Added "in place throughout the look-back period" to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the Explanation text regarding the four areas of focus to the subsection *Factors 1, 2: Four areas of focus* to clarify that the language applies to factors 1 and 2 (Element A).
- Added an example regarding clinical safety to the subhead *Patient safety* in the examples for factors 1,2 (Element A).
- Added "materials" as a data source and revised the scope of review to remove the reference to July 1, 2019 (Element B).
- Revised the look-back period for Renewal Surveys to 6 months for materials and 12 months for documented process (Element B).

Element A: Strategy Description—*Refer to Appendix 1 for points*

The strategy describes:

1. Goals and populations targeted for each of the four areas of focus.*

2. Programs or services offered to members.

3. Activities that are not direct member interventions.

4. How member programs are coordinated.

5. How members are informed about available PHM programs.

***Critical factors: Score cannot exceed 20% if critical factors are not met.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process

Scope of review *This element applies to Interim Surveys, First Surveys and Renewal Surveys.*

NCQA reviews a description of the organization's comprehensive PHM strategy that is in place throughout the look-back period. The strategy may be fully described in one document or the organization may provide a summary document with references or links to supporting documents provided in other PHM elements.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1 is a critical factor that the organization must meet to score higher than 20% on this element.

***Factors 1, 2:* Four areas of focus**

The organization has a comprehensive strategy for population health management that, *at a minimum,* addresses member needs in the following four areas of focus:

- Keeping members healthy.
- Managing members with emerging risk.
- Patient safety or outcomes across settings.
- Managing multiple chronic illnesses.

At a minimum, the description includes the following for each of the four areas of focus:

- A goal (factor 1).
- A target population (factor 1).
- A program or service (factor 2).

Goals are measurable and specific to a target population. A program is a collection of services or activities to manage member health. A service is an activity or intervention in which individuals can participate to help reach a specified health goal.

***Factor 3:* Activities that are not direct member interventions**

The organization describes all activities it conducts in support of PHM programs or services not directed at individual members. An activity may apply to more than one areas of focus. The organization has at least one activity in place.

***Factor 4:* Coordination of member programs**

The organization coordinates programs or services it directs and those facilitated by providers, external management programs and other entities. The PHM strategy describes how the organization coordinates programs across settings, providers and levels of care to minimize the confusion for members being contacted from multiple sources. Coordination activities are not required to be exclusive to one area of focus and may apply across the continuum of care and to other organization initiatives.

***Factor 5:* Informing members**

The organization describes its process for informing members about all available PHM programs and services, regardless of level of contact. The organization may make the information available on its website; by mail, email, text or other mobile application; by telephone; or in person.

Exceptions

None.

Examples

***Factors 1, 2:* Goals, target populations, opportunities, programs or services**

Keeping members healthy

- Goal: 55 percent of members in the target population report receiving annual influenza vaccinations.
  - Target populations:
    - Members with no risk factors.
    - Members enrolled in wellness programs.
  - *Programs or services:* Community flu clinics, email and mail reminders, radio and TV advertisement reminding the public to get vaccinated.
- Goal:10 percent of the target population reports meeting a self-determined weight-loss goal.
  - *Target population:* Members with BMI 27 or above enrolled in wellness program.
  - *Programs or services:* Wellness program focusing on weight management.

Managing members with emerging risk

- Goal: Lower or maintain HbA1c control <8.0% rate by 2 percent compared to baseline.
  - Target population:
    - Members discovered to be at risk for diabetes during predictive analysis.
    - Members with controlled diabetes.
  - *Programs or services:* Diabetes management program.
- Goal: Improve asthma medication ratio (total rate) by 3 percent compared to baseline.
  - *Target population:* Diagnosed asthmatic members 18–64 years of age with at least one outpatient visit in the prior year.
  - *Programs or services:* Condition management program.

Patient safety

- Goal: Improve the safety of high-alert medications.
  - *Target population:* Members who are prescribed high-alert medications and receive home health care.
  - *Activity:* Collaborate with community-based organizations to complete medication reconciliation during home visits.
- Goal: Improve clinical safety.
  - *Target population:* Members receiving in-patient surgical procedures.
  - *Activity:* Distribute information to members that facilitates informed decisions regarding care such as:
    - Questions to ask surgeons before surgery.
    - Questions to ask the practitioner about medication interactions.
    - Resources needed at discharge such as appropriate nutrition or transportation assistance.
  - *Activity:* Implement follow-up system to contact members after discharge to confirm receipt of care and post-surgical care instructions.

Outcomes across settings

- Goal: Reduce 30-day readmission rate after hospital stay (all causes) of 3 days or more by 2 percentage points compared to baseline.
  - *Target population:* Members admitted through the emergency department who remain in the hospital for three days or more.
  - *Program or services:* Organization-based case manager conducts a follow-up interview post-stay to coordinate needed care.
  - *Activity:* Collaborate with network hospitals to develop and implement a discharge planning process.

Managing multiple chronic illnesses

- Goal: Reduce ED visits in target population by 3 percentage points in 12 months.
  - *Target population:* Members with uncontrolled diabetes and cardiac episodes that led to hospital stay of two days or more.
  - *Programs or services:* Complex case management.
- Goal: Improve antidepressant medication adherence rate.
  - *Target population:* Members with multiple behavioral health diagnoses, including severe depression, who lack access to behavioral health specialists.
  - *Programs or services:* Complex case management with behavioral health telehealth counseling component.

***Factor 3:* Activities that are not direct member interventions**

- Share data and information with practitioners.
- Interactions and integration with delivery systems (e.g., contract with accountable care organizations).
- Provide technology support to or integrate with patient-centered medical homes.
- Integrate with community resources.
- Value-based payment arrangements.
- Collaborate with community-based organizations and hospitals to improve transitions of care from the post-acute setting to the home.
- Collaborate with hospitals to improve patient safety.

Element B: Informing Members—*Refer to Appendix 1 for points*

The organization informs members eligible for programs that include interactive contact:

1. How members become eligible to participate.

2. How to use program services.

3. How to opt in or opt out of the program.

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews the organization's policies and procedures in effect during the look-back period from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

For First Surveys and Renewal Surveys: NCQA also reviews materials sent to members from up to four randomly selected programs or services that involve interactive contact, or reviews all programs if the organization has fewer than four.

The score for the element is the average of the scores for all programs or services.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 6 months for materials; 12 months for documented process.

Explanation

This element applies to PHM programs or services in the PHM strategy that require interactive contact with members, including those offered directly by the organization.

Interactive contact

Programs with interactive contact have two-way interaction between the organization and the member, during which the member receives self-management support, health education or care coordination through one of the following methods:

- Telephone.
- In-person contact (i.e., individual or group).
- Online contact:
  - Interactive web-based module.
  - Live chat.
  - Secure email.
  - Video conference.

Interactive contact does not include:

- Completion of a health appraisal.
- Contacts made only to make an appointment, leave a message or verify receipt of materials.

Distribution of materials

The organization distributes information to members by mail, fax or email, or through messages to members' mobile devices, through real-time conversation or on its website, if it informs members that the information is available online. If the organization posts the information on its website, it notifies members that the information is available through another method listed above. The organization mails the information to members who do not have fax, email, telephone, mobile device or internet access. If the organization uses telephone or other verbal conversations, it provides a transcript of the conversation or script used to guide the conversation.

Factors 1–3: **Member information**

The organization provides eligible members with information on specific programs with interactive contact.

Exceptions

None.

Examples

Dear Member,

Because you had a recent hospital stay, you have been selected to participate in our Transitions Case Management Program. Sometime in the next three days, a nurse will call you to make sure you understand the instructions you were given when you left the hospital, and to make sure you have an appropriate provider to see for follow-up care.

To contact the nurse directly, call 555-555-1234. If you do not want to participate in the Transitions Case Management Program, let us know by calling 555-123-4567.

PHM 2: Population Identification—*Refer to Appendix 1 for points*

The organization systematically collects, integrates and assesses member data to inform its population health management programs.

Intent

The organization assesses the needs of its population and determines actionable categories for appropriate intervention.

Summary of Changes

Clarifications

- Revised the look-back period for First Surveys to 6 months and for Renewal Surveys to 12 months (Element A).
- Revised the first sentence of the Explanation for *Factor 1: Characteristics and needs* to state, "To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population" (Element B).
- Revised the look-back period for First and Renewal Surveys to state "at least once during the prior year" (Element C).
- Clarified the scope of review to state that NCQA reviews the most recent report for First Surveys and Renewal Surveys (Element D).
- Clarified the Explanation text under the subhead *Reports* to state that data may total more than 100 percent (Element D).

Element A: Data Integration—*Refer to Appendix 1 for points*

The organization integrates the following data to use for population health management functions:

1. Medical and behavioral claims or encounters.

2. Pharmacy claims.

3. Laboratory results.

4. Health appraisal results.

5. Electronic health records.

6. Health services programs within the organization.

7. Advanced data sources.

Scoring

100%	80%	50%	20%	0%
The organization meets 5-7 factors	The organization meets 3-4 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures for the types and sources of integrated data.

For First and Renewal Surveys: NCQA reviews reports or materials (e.g., screenshots) for evidence that the organization integrated data types and data from sources listed in the factors. The organization may submit multiple examples that collectively demonstrate integration from all data types and sources, or may submit one example that demonstrates integration of all data types and sources.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

Data integration is combining data from multiple sources databases. Data may be combined from multiple systems and sources (e.g., claims, pharmacy), across care sites (e.g., inpatient, ambulatory, home) and across domains (e.g., clinical, business, operational). The organization may limit data integration to the minimum necessary to identify eligible members and determine and support their care needs.

***Factor 1:* Claims or encounter data**

Requires both medical and behavioral claims or encounters. Behavioral claim data are not required if all purchasers of the organization's services carve out behavioral healthcare services (i.e., contract for a service or function to be performed by an entity other than the organization).

Factors 2, 3

No additional explanation required.

***Factor 4:* Health appraisals**

The organization demonstrates the capability to integrate data from health appraisals and health appraisals should be integrated if elected by plan sponsor.

***Factor 5:* Electronic health records**

Integrating EHR data from one practice or provider meets the intent of this requirement.

***Factor 6:* Health service programs within the organization.**

Relevant organization programs may include utilization management, care management or wellness coaching programs. The organization has a process for integrating relevant or necessary data from other programs to support identification of eligible members and determining care needs. Health appraisal results do not meet this factor.

***Factor 7:* Advanced data sources**

Advanced data sources aggregate data from multiple entities such as all-payer claims systems, regional health information exchanges and other community collaboratives. The organization must have access to the data to meet the intent of this factor.

Exceptions

None.

Examples

EHR integration

- Direct link from EHRs to data warehouse.
- Normalized data transfer or other method of transferring data from practitioner or provider EHRs.

Health services programs within the organization

- Case management.
- UM programs.
  - Daily hospital census data captured through UM.
  - Diagnosis and treatment options based on prior authorization data.
- Health information line.

Advanced data sources may require two-way data transfer. The organization and other entities can submit data to the source and can use data from the same source. These include but are not limited to:

- Regional, community or health system Health Information Exchanges (HIE).
- All-payer databases.
- Integrated data warehouses between providers, practitioners, and the organization with all parties contributing to and using data from the warehouse.
- State or regionwide immunization registries.

Element B: Population Assessment—*Refer to Appendix 1 for points*

The organization annually:

1. **Assesses the characteristics and needs, including social determinants of health, of its member population.**
2. **Identifies and assesses the needs of relevant member subpopulations.**
3. **Assesses the needs of child and adolescent members.**
4. **Assesses the needs of members with disabilities.**
5. **Assesses the needs of members with serious and persistent mental illness (SPMI).**

Scoring

100%	80%	50%	20%	0%
The organization meets 4-5 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys, NCQA reviews the organization's policies and procedures

For First and Renewal Surveys, NCQA reviews the organization's most recent annual assessment reports.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

The organization uses data at its disposal (e.g., claims, encounters, lab, pharmacy, utilization management, socioeconomic data, demographics) to identify the needs of its population.

***Factor 1:* Characteristics and needs**

To determine the necessary structure and resources for its PHM program, the organization assesses the characteristics and needs of the member population. The assessment includes the characteristics of the population and associated needs identified.

At a minimum, the organization assesses social determinants of health. Social determinants of health[1] are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks. The organization defines the determinants assessed.

Characteristics that define a relevant population may also include, but are not limited to:

- Federal or state program eligibility (e.g., Medicare or Medicaid, SSI, dual-eligible).
- Multiple chronic conditions or severe injuries.
- At-risk ethnic, language or racial group.

***Factor 2:* Identifying and assessing characteristics and needs of subpopulations**

The organization uses the assessment of the member population to identify and assess relevant subpopulations.

***Factor 3:* Needs of children and adolescents**

The organization assesses the needs of members 2–19 years of age (children and adolescents). If the organization's regulatory agency's definition of children and adolescents is different from NCQA's, the organization uses the regulatory agency's definition. The organization provides the definition to NCQA, which determines whether the organization's needs assessment is consistent with the definition.

***Factors 4, 5:* Individuals with disabilities and SPMI**

Members with disabilities and with serious and persistent mental illness (SPMI) have particularly acute needs for care coordination and intense resource use (e.g., prevalence of chronic diseases).

Exception

Factor 3 is NA for the Medicare product line.

[1]https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

Examples

***Factors 1, 2:* Relevant characteristics**

- Social determinants of health include:
  - Resources to meet daily needs.
  - Safe housing.
  - Local food markets.
  - Access to educational, economic and job opportunities.
  - Access to health care services.
  - Quality of education and job training.
  - Availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities.
  - Transportation options.
  - Public safety.
  - Social support.
  - Social norms and attitudes (e.g., discrimination, racism, and distrust of government).
  - Exposure to crime, violence and social disorder (e.g., presence of trash and lack of cooperation in a community).
  - Socioeconomic conditions.
  - Residential segregation.
  - Language/literacy.
  - Access to mass media and emerging technologies.
  - Culture.
- Physical determinants include:
  - Natural environment, such as green space (e.g., trees and grass) or weather (e.g., climate change).
  - Built environment, such as buildings, sidewalks, bike lanes and roads.
  - Worksites, schools and recreational settings.
  - Housing and community design.
  - Exposure to toxic substances and other physical hazards.
  - Physical barriers, especially for people with disabilities.
  - Aesthetic elements (e.g., good lighting, trees, benches).
  - Eligibility categories included in Medicaid managed care (e.g., TANF, low-income, SSI, other disabled).
  - Nature and extent of carved out benefits.
  - Type of Special Needs Plan (SNP) (e.g., dual eligible, institutional, chronic).
  - Race/ethnicity and language preference.

Element C: Activities and Resources—*Refer to Appendix 1 for points*

The organization annually uses the population assessment to:

1. **Review and update its PHM activities to address member needs.**
2. **Review and update its PHM resources to address member needs.**
3. **Review community resources for integration into program offerings to address member needs.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First and Renewal Surveys: NCQA reviews committee minutes or similar documents showing process and resource review and updates.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

***Factors 1, 2:* PHM activities and resources**

The organization uses assessment results to review and update its PHM structure, strategy (including programs, services, activities) and resources (e.g., staffing ratios, clinical qualifications, job training, external resource needs and contacts, cultural competency) to meet member needs.

***Factor 3:* Community resources**

The organization connects members with community resources or promotes community programs. Integrating community resources indicates that the organization actively and appropriately responds to members' needs. Community resources correlate with member needs discovered during the population assessment.

Actively responding to member needs is more than posting a list of resources on the organization's website; active response includes referral services and helping members access community resources.

Exceptions

None.

Examples

Community resources and programs

- Population assessment determines a high population of elderly members without social supports. The organization partners with the Area Agency on Aging to help with transportation and meal delivery.
- Connect at-risk members with shelters.
- Connect food-insecure members with food security programs or sponsor community gardens.

- Sponsor or set up fresh food markets in communities lacking access to fresh produce.
- Participate as a community partner in healthy community planning.
- Partner with community organizations promoting healthy behavior learning opportunities (e.g., nutritional classes at local supermarkets, free fitness classes).
- Support community improvement activities by attending planning meetings or sponsoring improvement activities and efforts.
- Social workers or other community health workers that contact members to connect them with appropriate community resources.
- Referrals to community resources based on member need.
- Discounts to health clubs or fitness classes.

Element D: Segmentation—*Refer to Appendix 1 for points*

At least annually, the organization segments or stratifies its entire population into subsets for targeted intervention.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source Documented process, Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For All Surveys: NCQA reviews a description of the method used.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's most recent report demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

Population segmentation divides the population into meaningful subset using information collected through population assessment and other data sources.

Risk stratification uses the potential risk or risk status of individuals to assign them to tiers or subsets. Members in specific subsets may be eligible for programs or receive specific services.

Segmentation and risk stratification result in the categorization of individuals with care needs at all levels and intensities. Segmentation and risk stratification is a means of targeting resources and interventions to individuals who can most benefit from them. Either process may be used to meet this element.

Methodology

The organization describes its method for segmenting or stratifying its membership, including the subsets to which members are assigned (e.g., high-risk pregnancy, multiple inpatient admissions). The organization may use more than one risk stratification methods to determine actionable subsets.

Segmentation and stratification use population assessment and data integration findings (e.g., clinical and behavioral data, population and social needs) to determine subsets and programs or services for which members are eligible. Although these methods may include utilization/resource use or cost information. Methods that use only cost information for segmentation and stratification do not meet the intent of this element.

Reports

The organization provides reports specifying the number of members in each category and the programs or services for which they are eligible. Reports may be a "point-in-time" snapshot during the look-back period.

Reports reflect the number of members eligible for each PHM program. They display data in raw numbers and as a percentage of the total enrolled member population, and may total more than 100% if members fall into more than one category.

PHM programs or services provided to members include, but are not limited to, complex case management.

Exceptions

None.

Examples

Health Plan A: **Commercial HMO/PPO**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Pregnancy: Over 35 years, multiple gestation	High-risk pregnancy care management	55	0.5%
Type I Diabetes: Moderate risk	Diabetes management	660	6%
Tobacco use	Smoking cessation	110	1%
Behavioral health diagnosis in ages 15-19, rural	Telephone or video behavioral health counseling sessions	330	3%
Women of child-bearing age	Targeted women's health newsletter	3,850	35%
No risk factors	Routine member newsletters	2,750	25%
No associated data	None	3,850	35%

Health Plan A: **Medicare**

Subset of Population	Targeted Intervention for Which Members Are Eligible	Number of Members	Percentage of Membership
Multiple chronic conditions	Complex case management: Over 65	2,000	5%
Over 65, needs assistance with 2 or more ADLs	Long-term services and supports	2,800	7%
COPD: High risk	Complex case management: Over 65	1,600	4%
Osteoporosis: High-risk women	Targeted member newsletter	8,800	22%
BMI over 30	Weight management program	4,800	12%
No risk factors	Routine member newsletters	12,000	30%
No associated data	None	8,000	20%

PHM 3: Delivery System Supports—*Refer to Appendix 1 for points*

The organization describes how it supports the delivery system, patient-centered medical homes and use of value-based payment arrangements.

Intent

The organization works with practitioners or providers to achieve population health management goals.

Summary of Changes

Clarifications

- Added "in place throughout the look-back period" to the scope of review for documented process (Element A).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months (Element A).
- Moved the examples for *Factor 3: Providing practice transformation support to primary care practitioners* as the third paragraph under *Related information* (Element A).
- Revised the scoring language for 100% and 0% (Element B).
- Revised the look-back period for First Surveys to 6 months and Renewal Surveys to 12 months (Element B).

Element A: Practitioner or Provider Support—*Refer to Appendix 1 for points*

The organization supports practitioners or providers in its network to achieve population health management goals by:

1. Sharing data.

2. Offering evidence-based or certified decision-making aids.

3. Providing practice transformation support to primary care practitioners.

4. Providing comparative quality information on selected specialties.

5. Providing comparative pricing information on selected services.

6. One additional activity to support practitioners or providers in achieving PHM goals.

Scoring

100%	80%	50%	20%	0%
The organization meets 3-6 factors	The organization meets 2 factors	No scoring option	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's description of how it supports practitioners or providers.

For First Surveys and *Renewal Surveys:* NCQA reviews the organization's description that is in place throughout the look-back period of how it supports practitioners or providers and materials demonstrating implementation.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 12 months.

Explanation

The organization identifies and implements activities that support practitioners and providers in meeting population health goals. Practitioners and providers may include accountable care entities, primary or specialty practitioners, PCMHs, or other providers included in the organization's network. Organizations may determine the practitioners or providers they support.

***Factor 1:* Data sharing**

Data sharing is transmission of member data from the health plan to the provider or practitioner that assists in delivering services, programs, or care to the member. The organization determines the frequency for sharing data.

***Factor 2:* Evidence-based or certified decision-making aids**

Shared decision-making (SDM) aids provide information about treatment options and outcomes. SDM aids are designed to complement practitioner counselling, not replace it. SDM aids facilitate member and practitioner discussion on treatment decisions.

SDM aids may focus on preference-sensitive conditions, chronic care management or lifestyle changes, to encourage patient commitment to self-care and treatment regimens.

SDM aids are certified by a third party that evaluates quality, or are created using evidence-based criteria. If certified, the organization provides information about how, when, under what conditions and to whom certified SDM aids are offered. If created using evidence-based criteria, criteria must be cited. At least one certified or evidence-based SDM aid must be offered to meet the intent.

***Factor 3:* Practice transformation support**

Transformation includes movement to becoming a more-integrated or advanced practice (e.g., ACO, PCMH) and toward value-based care delivery.

The organization provides documentation that it supports practice transformation.

***Factor 4:* Comparative quality and cost information on selected specialties**

The organization provides comparative quality information about selected specialties to practitioners or providers and reports cost information if it is available. Comparative cost information may be cost or efficiency information and may be represented as relative rates or as a relative range.

Comparative quality information may be reported without cost information if cost information is not available.

To meet this requirement, the organization must provide quality information (with or without cost information) for at least one specialty and show that it has provided the information to at least one provider that refers members to the specialty.

***Factor 5:* Comparative pricing information for selected services**

Comparative pricing information may contain actual unit prices per service or relative prices per service, compared across practitioners or providers.

To meet this requirement, the organization must provide comparative pricing information on at least one service and show that it has provided the information to at least one provider that prescribes the service to members.

***Factor 6:* Another activity**

Other activities include those that cannot be categorized in factors 1–5. The organization describes the activity, how it supports providers or practitioners and how it contributes to achieving PHM goals.

Data sharing activities that use a different method of data sharing from that in factor 1 may be used to meet this factor. The method indicates how data are shared.

Exceptions

None.

Related information

Partners in Quality. The organization receives automatic credit for factors 3 and 6 if it is an NCQA-designated Partner in Quality.

The organization must provide documentation of its status.

Practice transformation support. The organization can support its practitioners/providers in meeting their population health management goals by any of the following methods:

- Incentive payments for PCMH arrangement.
- Technology support.
- Best practices.
- Supportive educational information, including webinars or other education sessions.
- Help with application fees for NCQA PCMH Recognition (beyond the NCQA program's sponsor discount).
- Help practices transform into a medical home.
- Provide incentives for NCQA PCMH Recognition, such as pay-for-performance.
- Use NCQA PCMH Recognition as a criterion for inclusion in a restricted or tiered network.

Examples

Factor 1

- Sharing patient-specific data listed below that the practitioner or provider does not have access to:
  - Pharmacy data.
  - ED reports.
  - Enrollment data.
  - Eligibility in the organization's intervention programs (e.g., enrollment in a wellness or complex case management program).
  - Reports on gaps in preventive services (e.g., a missed mammogram, need for a colonoscopy).
    - Claims data indicate if these services were not done; practitioners or staff can remind members to receive services.
  - Claims data.
  - Data generated by specialists, urgent care clinics or other care providers.

- Methods of data sharing:
  - Transmitted through electronic channels as "raw" data to practitioners who conduct data analysis to drive improved patient outcomes.
  - Practitioner or provider portals that have accessible patient-specific data.
  - Submit data to a regional HIE.
  - Reports created for practitioners or providers about patients or the attributed population.
  - A direct link to EHRs, to automatically populate recent claims for relevant information and alert practitioners or providers to changes in a patient's health status.

Factor 2

- Certification bodies:
  - National Quality Forum.
  - Washington State Health Care Authority.

Factor 4

- Selected specialties:
  - Specialties that a primary care practitioner refers members to most frequently.
- Quality information:
  - Organization-developed performance measures based on evidence-based guidelines.
    - AHRQ patient safety indicators associated with a provider.
    - In-patient quality indicators.
    - Risk-adjusted measures of mortality, complications and readmission.
    - Physician Quality Reporting System (PQRS) measures.
    - Non-PQRS Qualified Clinical Data Registry (QCDR) measures.
    - CAHPS measures.
  - The American Medical Association's Physician Consortium for Performance Improvement (PCPI) measures.
  - Cost information:
    - Relative cost of episode of care.
    - Relative cost of practitioner services.
  - In-office procedures.
  - Care pattern reports that include quality and cost information.

Factor 5

- Selected services:
  - Services for which the organization has unit price information.
  - Services commonly requested by primary care practitioners that are not conducted in-office.
  - Radiology services.
  - Outpatient procedures.
  - Pharmaceutical costs.

Factor 6

- Health plan staff located full-time at the provider facility to assist with member issues.
- The ability to view evidence-based practice guidelines on demand (e.g., practitioner portal).
- Incentives for two-way data sharing.

Element B: Value-Based Payment Arrangements—*Refer to Appendix 1 for points*

The organization demonstrates that it has a value-based payment (VBP) arrangement(s) and reports the percentages of total payments tied to VBP.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First Surveys and Renewal Surveys: NCQA reviews the VBP worksheet to demonstrate that it has VBP arrangements in each product line.

The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

There is broad consensus that payment models need to evolve from payment based on volume of services provided to models that consider value or outcomes. The fee-for-service (FFS) model does not adequately address the importance of non-visit-based care, care coordination and other functions that are proven to support achievement of population health goals.

The organization demonstrates that it has at least one VBP arrangement and reports the percentage of total payments made to providers and practitioners associated with each type of VBP arrangement.

The organization uses the following VBP types, sourced from *CMS Report to Congress: Alternative Payment Models and Medicare Advantage* to report arrangements to NCQA. The organization is not required to use them for internal purposes. If the organization uses different labels for its VBP arrangements, it categorizes them using the NCQA provided definitions.

- *Pay-for-performance (P4P):* Payments are for individual units of service and triggered by care delivery, as under the FFS approach, but providers or practitioners can qualify for bonuses or be subject to penalties for cost and/or quality related performance. Foundational payments or payments for supplemental services also fall under this payment approach.
- *Shared savings:* Payments are FFS, but provider/practitioners who keep medical costs below the organization's established expectations retain a portion (up to 100 percent) of the savings generated. Providers/practitioners who qualify for a shared savings award must also meet standards for quality of care, which can influence the portion of total savings the provider or practitioner retains.
- *Shared risk:* Payments are FFS, but providers/practitioners whose medical costs are above expectations, as predetermined by the organization, are liable for a portion (up to 100 percent) of cost overruns.

- *Two-sided risk sharing:* Payments are FFS, but providers/practitioners agree to share cost overruns in exchange for the opportunity to receive shared savings.
- *Capitation/population-based payment:* Payments are not tied to delivery of services, but take the form of a fixed per patient, per unit of time sum paid in advance to the provider/practitioner for delivery of a set of services (partial capitation) or all services (full or global capitation). The provider/practitioner assumes partial or full risk for costs above the capitation/ population-based payment amount and retains all (or most) savings if costs fall below the capitation/population-based payment amount. Payments, penalties and awards depend on quality of care.

Calculating VBP reach

Percentage of payments is calculated by:

- *Numerator:* Total payments made to network practitioners/providers in contracts tied to VBP arrangement(s), divided by,
- *Denominator:* Total payments made to all network providers/practitioners in all contracts, including traditional FFS.

The percentage of payments can reflect the current year to date or the previous year's payments, and can be based on allowed amounts, actual payments or forecasted payments.

Types of providers/practitioners

For each type of VBP arrangement, the organization reports a percentage of total payments and indicates the provider/practitioner types included in the arrangement.

Exceptions

None.

Examples None.

PHM 4: Wellness and Prevention—*Refer to Appendix 1 for points*

The organization offers wellness services focused on preventing illness and injury, promoting health and productivity and reducing risk.

Intent

The organization helps adult members identify and manage health risks through evidence-based tools that maintain member privacy and explain how the organization uses collected information.

Summary of Changes

Clarifications

- Revised the look-back period from 6 months to 12 months for Renewal Surveys, for factor 14 (Element C).
- Added "throughout the look-back period" to the scope of review for documented process (Elements I, J).
- Clarified in the Explanation for *Factor 2: Members with special needs* that vision and hearing must be addressed to receive credit for the factor (Element I).

Element A: Health Appraisal Components—*Refer to Appendix 1 for points*

The organization's HA includes the following information:

1. **Questions on demographics.**
2. **Questions on health history, including chronic illness and current treatment.**
3. **Questions on self-perceived health status.**
4. **Questions to identify effective behavioral change strategies.**
5. **Questions to identify members with special hearing and vision needs and language preference.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

HAs help identify at-risk and high-risk members, determine focus areas for timely intervention and prevention efforts and monitor risk change over time. They are an educational tool that can engage members in making healthy behavior changes.

The questions required by the factors gather information to determine members' overall risk or wellness, allowing the organization to tailor services and activities.

***Factor 1:* Demographics**

Member demographics include age, gender and ethnicity.

***Factor 2:* Personal health history**

No additional explanation required.

***Factor 3:* Self-perceived health status**

Self-perceived health status is a members' assessment of current health status and well-being.

***Factor 4:* Behavioral change strategies**

The HA includes questions to help guide changes in behavior and reduce risk.

***Factor 5:* Special needs assessment**

The HA includes questions that assess hearing and vision impairment and language preferences to help the organization provide special services, materials or equipment to members as needed. To meet this factor, questions must include all three special needs: hearing, vision impairment and language preferences.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 1:* Demographics**

- Age.
- Gender.
- Race or ethnicity.
- Level of education.
- Level of income.
- Marital status.
- Number of children.

***Factor 2:* Personal health history**

- Do you have any of the following conditions?
- Have you had any of the following conditions?
- Do you smoke or use tobacco? How long has it been since you smoked or used tobacco?
- When did you last receive the following preventive services or screenings?

***Factor 3:* Self-perceived health status**

- SF 20® questions or other questions where participants rate their health status on a relative scale.

***Factor 4:* Behavioral change theories and models**

- Prochaska's Stages of Change.
- Patient Activation Measure.
- Knowledge-Attitude Behavior Model.
- Health Belief Model.
- Theory of Reasoned Action.
- Bandura's Social Cognitive Theory.

***Factor 5:* Special needs assessment**

- Do you have a vision impairment that requires special reading materials?
- Do you have a hearing impairment that requires special equipment?
- Is English your primary language? If not, what language do you prefer to speak?

Element B: Health Appraisal Disclosure—*Refer to Appendix 1 for points*

The organization's HA includes the following information in easy-to-understand language:

1. **How the information obtained from the HA will be used.**
2. **A list of organizations and individuals who might receive the information, and why.**
3. **A statement that participants may consent or decline to have information used and disclosed.**
4. **How the organization assesses member understanding of the language used to meet factors 1–3.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Materials

Scope of review *This element applies to First Surveys and Renewal Surveys.*

NCQA reviews the organization's HA for factors 1–3 and reviews policies and procedures for factor 4. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Use of HA information**

No additional explanation required.

***Factor 2:* Information recipients**

A list of the organizations and individuals who will receive the information, and why, is required. Organizations and individuals are identified by role and are not required to be identified by name.

***Factor 3:* Right to consent or decline**

The HA may include a statement that the member accepts or declines participation or a notice that completion and submission implies consent to the HA's stated use. If the opportunity to consent or decline is associated with HA completion, members have access to the organization's definition of "HA completion." For online consent forms, disclosure information is available in printed form.

***Factor 4:* Assessing member understanding**

The HA is not expected to have language regarding how the organization assesses member understanding of HA disclosure requirements. NCQA reviews the organization's documented process for assessing member understanding.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 2:* Information recipients**

- An organization that contracts directly with an employer or plan sponsor may disclose information to the participant's health plan. Because the employer or plan sponsor could change health plans, the organization may identify that it "disclose[s] information to the participant's health plan," instead of identifying the plan by name.
- An organization that has a direct relationship with practitioners may disclose information to a participant's primary care practitioner. Because the participant might change practitioners, the organization may identify that it "disclose[s] information to the member's primary care physician," instead of identifying the practitioner by name.

Element C: Health Appraisal Scope—*Refer to Appendix 1 for points*

HAs provided by the organization assess at least the following personal health characteristics and behaviors:

1. **Weight.**
2. **Height.**
3. **Smoking and tobacco use.**
4. **Physical activity.**
5. **Healthy eating.**
6. **Stress.**
7. **Productivity or absenteeism.**
8. **Breast cancer screening.**
9. **Colorectal cancer screening.**
10. **Cervical cancer screening.**
11. **Influenza vaccination.**
12. **At-risk drinking.**
13. **Depressive symptoms.**
14. **Safety behaviors.**

Scoring

100%	80%	50%	20%	0%
The organization meets 13-14 factors	The organization meets 11-12 factors	The organization meets 7-10 factors	The organization meets 3-6 factors	The organization meets 0-2 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's HA that is available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen

shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months; 12 months for factor 14.

Explanation

The organization offers an HA with questions that address the scope of areas evaluated by this element, even if no employers or plan sponsors purchase an HA that addresses the full scope listed in the factors.

Factors 1–13

No additional explanation required.

***Factor 14:* Safety behaviors**

Safety behaviors include, but are not limited to, wearing protective gear when recommended or wearing seat belts in motor vehicles. Evidence may not reveal a consistent set of validated questions, but safety behavior is closely associated with other modifiable risk areas, where validated questions exist.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Validated survey items. Evidence shows that certain HA items produce valid and reliable results for key health characteristics and behaviors listed in the factors. NCQA recommends that organizations use validated survey items on their HAs. Refer to the *Technical Specifications for Wellness & Health Promotion* publication for suggested validated survey items. The specifications are available through the *Publications and Products* section of the NCQA website.

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

***Factor 7:* Productivity or absenteeism**

- Work days missed due to personal or family health issues.
- Time spent on personal or family health issues during the work day.

Element D: Health Appraisal Results—*Refer to Appendix 1 for points*

Participants receive their HA results, which include the following information in language that is easy to understand:

1. An overall summary of the participant's risk or wellness profile.

2. A clinical summary report describing individual risk factors.

3. Information on how to reduce risk by changing specific health behaviors.

4. Reference information that can help the participant understand the HA results.

5. A comparison to the individual's previous results, if applicable.

Scoring

100%	80%	50%	20%	0%
The organization meets all 5 factors	The organization meets 4 factors	The organization meets 3 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating the understandability of HA results and reviews HA results.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots of web functionality, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

For factors 2–5, NCQA also reviews HA results for evidence that they contain all the health characteristics and behaviors listed in Element C.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Easy-to-understand language

The organization presents information clearly and uses words with common meanings, to the extent practical.

***Factor 1:* Overall summary of risk and wellness profile**

HA results include:

- An evidenced-based summary or profile of the participant's overall level of risk or wellness.
- The core health areas (healthy weight [BMI] maintenance, smoking and tobacco use cessation, encouraging physical activity, healthy eating, managing stress, clinical preventive services).

Factor 2: **Clinical summary report**

A clinical summary report describes the risk factors that the HA identifies and is in a format that can be shared with a participant's practitioner.

Factor 3: **Reducing risk and changing behavior**

HA results identify specific behaviors that can lower each risk factor and include recommended targets for improvement and information on how to reduce risk.

Factor 4: **Reference information**

HA results include additional resources or information external to the organization that participants can use to learn more about their specific health risks and behaviors to improve their health and well-being.

Factor 5: **Comparing HA results**

If a participant previously completed an HA administered by the organization, the organization includes comparison information to the previous HA results in the current report.

Exceptions

Factor 5 is NA if the organization has not previously administered an HA.

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples None.

Element E: Health Appraisal Format—*Refer to Appendix 1 for points*

The organization makes HAs available in language that is easy to understand, in the following formats:

1. Digital services.

2. In print or by telephone.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for evaluating understandability, digital HA and printed or telephonic HA. Each format must be in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The organization is capable of making HAs available through digital media, printed copies or telephone, even if no employers or plan sponsors purchase HAs in multiple formats.

Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

***Factor 1:* Digital services**

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

The printed version of the HA contains the same content as the web version of the HA.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

Element F: Frequency of Health Appraisal Completion—*Refer to Appendix 1 for points*

The organization has the capability to administer the HA annually.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for administering annual HAs, or documentation that the organization administered an annual HA.

Look-back period

For First Surveys: At least once during the prior year.
For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities evaluated by this element, even if it does not provide services to any employer or plan sponsor.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Evidence of capability to administer

- Contracts that specify at least annual administration of the HA.
- Reports that demonstrate at least annual administration of the HA.

Element G: Health Appraisal Review and Update Process —*Refer to Appendix 1 for points*

The organization reviews and updates the HA every two years, and more frequently if new evidence is available.

Scoring

100%	80%	50%	20%	0%
The organization meets the requirement	No scoring option	No scoring option	No scoring option	The organization does not meet the requirement

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for reviewing and updating its HA. The policies and procedures must be in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews evidence that the organization reviewed and updated the HA every two years or more frequently if new evidence is available that warrants an update.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

No explanation required.

Exception

This element is NA for the Medicaid product line if the state conducts its own HA or mandates a tool for the organization to conduct HAs. The organization must present documentation demonstrating the state requirement.

Related information

Use of vendors for HA services. If the organization contracts with a vendor to provide HA services, it provides access to the vendor's HA. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's HA against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Evidence of review

- Analysis of HA against current or new evidence.
- Documentation in meeting minutes or reports demonstrating review and update of the HA occurred.

Element H: Topics of Self-Management Tools—*Refer to Appendix 1 for points*

The organization offers self-management tools, derived from available evidence, that provide members with information on at least the following wellness and health promotion areas:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures for developing evidence based self-management tools, and reviews the organization's self-management tools. Both must be available throughout the look-back period.

If the organization can provide a "test" or "demo" log-on ID, NCQA reviews the organization's performance through that mechanism. If the organization cannot provide a test or demo log-on, NCQA reviews the organization's website or screen shots, supplemented with documents specifying the required features and functions of the site. If screen shots provided include detailed explanations of how the site works, there is no need to provide supplemental documents.

Look-back period

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The organization provides evidence that it can perform all activities required by this element, even if it does not provide services to any employer or plan sponsor.

Self-management tools

Self-management tools help members determine risk factors, provide guidance on health issues, recommend ways to improve health or support reducing risk or maintaining low risk. They are interactive resources that allow members to enter specific personal information and provide immediate, individual results based on the information. This element addresses self-management tools that members can access directly from the organization's website or through other methods (e.g., printed materials, health coaches).

Evidence-based information

The organization meets the requirement of "evidenced-based" information if recognized sources are cited prominently in the self-management tools.

If the organization's materials do not cite recognized sources, NCQA also reviews the organization's documented process detailing the sources used, and how they were used in developing the self-management tools.

Factors 1–7

No additional explanation required.

Exceptions

None.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Self-management tools

- Interactive quizzes.
- Worksheets that can be personalized.
- Online logs of physical activity.
- Caloric intake diary.
- Mood log.

Element I: Usability Testing of Self-Management Tools—*Refer to Appendix 1 for points*

For each of the required seven health areas in Element H, the organization evaluates its self-management tools for usefulness to members at least every 36 months, with consideration of the following:

1. Language is easy to understand.

2. Members' special needs, including vision and hearing, are addressed.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures in place throughout the look-back period, and reviews evidence of usability testing for each of the seven health areas. The score for the element is the average of the scores for all health areas.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior 36 months.

Explanation

Usability

The organization is not required to conduct usability testing with an external audience. Testing with internal staff who were not involved in development of the self-management tool meets the requirements of this element, if staff are representative of the population that will use the tool.

Factor 1: Easy-to-understand language

The organization presents information clearly and uses words with common meaning, to the extent practical.

Factor 2: Members with special needs

The organization's documented process explains the methods used to identify usability issues for members with special needs. Vision and hearing must be addressed to receive credit for this factor.

Exception

Factors marked "No" in Element H are scored NA in this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

Guidelines on usability testing for online tools

- www.usability.gov.

Evaluation methods

- Focus groups.
- Cognitive testing and surveys that focus on specific tools.

Element J: Review and Update Process for Self-Management Tools
—Refer to Appendix 1 for points

The organization demonstrates that it reviews its self-management tools on the following seven health areas and updates them every two years, or more frequently if new evidence is available:

1. Healthy weight (BMI) maintenance.

2. Smoking and tobacco use cessation.

3. Encouraging physical activity.

4. Healthy eating.

5. Managing stress.

6. Avoiding at-risk drinking.

7. Identifying depressive symptoms.

Scoring

100%	80%	50%	20%	0%
The organization meets all 7 factors	The organization meets 5-6 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures in place throughout the look-back period.

For Renewal Surveys: NCQA also reviews documentation that shows review and update of the self-management tools.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

Factors 1–7

No explanation required.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

Element K: Self-Management Tool Formats—*Refer to Appendix 1 for points*

The organization's self-management tools are offered in the following formats for each of the required seven health areas:

1. Digital services.

2. In print or by telephone.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Documented process, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA scores this element for each of seven required health areas in Element H. The score for the element is the average of the scores for all health areas.

NCQA reviews the organization's digital and printed or telephonic self-management tools in place throughout the look-back period. NCQA accepts screen shots for factor 1 and telephone scripts for factor 2.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

The content of self-management tools is the same in all formats.

***Factor 1:* Digital services**

Digital services include online, internet-based access and downloadable applications for smartphones and other devices.

***Factor 2:* In print or by telephone**

Materials must be available in printed format or by telephone. An option to print an online document does not meet the requirement.

Exception

Factors marked "No" in Element H are scored NA for this element.

Related information

Use of vendors for self-management tool services. If the organization contracts with a vendor to provide self-management tools, it provides access to the vendor's self-management tools. NCQA does not consider the relationship to be delegation, and delegation oversight is not required under PHM 7. NCQA evaluates the vendor's self-management tools against the requirements. Refer to *Vendor Relationships* in Appendix 5.

Examples

None.

PHM 5: Complex Case Management—*Refer to Appendix 1 for points*

The organization coordinates services for its highest risk members with complex conditions and helps them access needed resources.

Intent

The organization helps members with multiple or complex conditions to obtain access to care and services, and coordinates their care.

Summary of Changes

Clarifications

- Clarified the scope of review for First and Renewal Surveys to state that policies and procedures are in place throughout the look-back period (Element C).
- Revised the look-back period for Renewal Surveys from 6 months to 12 months for factors 3, 5 and 11 (Element C).
- Moved the second paragraph of the Explanation under the subhead *Assessment and evaluation* (Element C).
- Clarified under the subhead *Assessment and evaluation* that the policies describe the process to collect information and document summary (Element C).
- Clarified the explanation under *factor 5 (social determinants of health)* to state that the organization considers more than one social determinant of health (Elements C, D).
- Moved "Time frames are specified in the case management plan" to be a subbullet under *Time frames for reevaluation* in the Explanation for factor 12 (Element C).
- Revised the look-back period to 12 months for Renewal Surveys, for all factors (Element D).
- Divided the Explanation for *Factor 1: Case management plans and goals* into two paragraphs and added text to clarify that goals must be both timebound and prioritized (Element E).

Element A: Access to Case Management—*Refer to Appendix 1 for points*

The organization has multiple avenues for members to be considered for complex case management services, including:

1. Medical management program referral.

2. Discharge planner referral.

3. Member or caregiver referral.

4. Practitioner referral.

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews evidence that the organization has multiple referral avenues in place throughout the look-back period and that it communicates the referral options to members and practitioners at least once during the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months.

Explanation

The overall goal of complex case management is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

NCQA considers complex case management to be an opt-out program: All eligible members have the right to participate or to decline to participate.

The organization offers a variety of programs to its members and does not limit eligibility to one complex condition or to members already enrolled in the organization's DM program.

In addition to the process described in PHM 2, Element D: Segmentation, multiple referral avenues can minimize the time between identification of a need and delivery of complex case management services.

The organization has a process for facilitating referrals listed in the factors, even if it does not currently have access to the source.

Factor 1

Medical management program referrals include referrals that come from other organization programs or through a vendor or delegate. These may include disease management programs, UM programs, health information lines or similar programs that can identify needs for complex case management and are managed by organization or vendor staff.

Factor 2

No additional explanation required.

Factors 3, 4

The organization communicates referral options to members (factor 3) and practitioners (factor 4).

Exceptions

None.

Examples

Facilitating referrals

- Correspondence from members, caregivers or practitioners about potential eligibility.
- Monthly or quarterly reports, from various sources, of the number of members identified for complex case management.

- Brochures or mailings to referral sources about the complex case management program and instructions for making referrals.
- Web-based materials with information about the case management program and instructions for making referrals.

Element B: Case Management Systems—*Refer to Appendix 1 for points*

The organization uses case management systems that support:

1. **Evidence-based clinical guidelines or algorithms to conduct assessment and management.**
2. **Automatic documentation of staff ID, and the date and time of action on the case or when interaction with the member occurred.**
3. **Automated prompts for follow-up, as required by the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports, Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

For Interim Surveys: NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA also reviews the organization's complex case management system or annotated screenshots of system functionality. The system must be in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.
For First Surveys: 6 months.
For Renewal Surveys: 24 months.

Explanation

***Factor 1:* Evidence-based clinical guidelines or algorithms**

The organization develops its complex case management system through one of the following sources:

- Clinical guidelines, ***or***
- Algorithms, ***or***
- Other evidence-based materials.

NCQA does not require the entire evidence-based guideline or algorithm to be imbedded in the automated system, but the components used to conduct assessment and management of patients must be imbedded in the system.

***Factor 2:* Automated documentation**

The complex case management system includes automated features that provide accurate documentation for each entry (record of actions or interaction with members, practitioners or providers) and use automatic date, time and user (user ID or name) stamps.

Factor 3: **Automated prompts**

The complex case management system includes prompts and reminders for next steps or follow-up care.

Exceptions

None.

Examples None.

Element C: Case Management Process—*Refer to Appendix 1 for points*

The organization's complex case management procedures address the following:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living.**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Initial assessment of life-planning activities.**
7. **Evaluation of cultural and linguistic needs, preferences or limitations.**
8. **Evaluation of visual and hearing needs, preferences or limitations.**
9. **Evaluation of caregiver resources and involvement.**
10. **Evaluation of available benefits.**
11. **Evaluation of community resources.**
12. **Development of an individualized case management plan, including prioritized goals and considers member and caregiver goals, preferences and desired level of involvement in the case management plan.**
13. **Identification of barriers to the member meeting goals or complying with the case management plan.**
14. **Facilitation of member referrals to resources and a follow-up process to determine whether members act on referrals.**
15. **Development of a schedule for follow-up and communication with members.**
16. **Development and communication of a member self-management plan.**
17. **A process to assess member progress against the case management plan.**

Scoring

100%	80%	50%	20%	0%
The organization meets 16-17 factors	The organization meets 12-15 factors	The organization meets 8-11 factors	The organization meets 3-7 factors	The organization meets 0-2 factors

Data source Documented process

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews the organization's policies and procedures.

For First Surveys and Renewal Surveys: NCQA reviews the organization's policies and procedures in place throughout the look-back period.

Look-back period

For Interim Surveys: Prior to the survey date.

For First Surveys: 6 months.

For Renewal Surveys: 24 months; 12 months for factors 3, 5 and 11.

Explanation

This is a structural requirement. The organization must present its own documentation.

Assessment and evaluation

Assessment and evaluation each require the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. Policies describe the process to both collect information and document a summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Complex case management policies and procedures state why an assessment might not be appropriate for a factor (e.g., life-planning activities, in pediatric cases) and specify that the organization documents such assessment in the case management system and file.

***Factor 1:* Initial assessment of members' health status**

Complex case management policies and procedures specify the process for initial assessment of health status, specific to an identified condition and likely comorbidities (e.g., high-risk pregnancy and heart disease, for members with diabetes). The assessment includes:

- Screening for presence or absence of comorbidities and their current status.
- Member's self-reported health status.
- Information on the event or diagnosis that led to the member's identification for complex case management.

***Factor 2:* Documentation of clinical history**

Complex case management policies and procedures specify the process for documenting clinical history (e.g., disease onset; acute phases; inpatient stays; treatment history; current and past medications, including schedules and dosages).

***Factor 3:* Initial assessment of activities of daily living**

Complex case management policies and procedures specify the process for assessing functional status related to at least the six basic ADLs: bathing, dressing, going to the toilet, transferring, feeding and continence.

***Factor 4:* Initial assessment of behavioral health status**

Complex case management policies and procedures specify the process for assessing behavioral health status, including:

- Cognitive functions:
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.

- Mental health conditions.
- Substance use disorders.

Factor 5: **Initial assessment of social determinants of health**

Complex case management policies and procedures specify the process for assessing social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet case management goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

Factor 6: **Initial assessment of life-planning activities**

Complex case management policies and procedures specify the process for assessing whether members have completed life-planning activities such as wills, living wills or advance directives, health care powers of attorney and Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Providing life-planning information (e.g., brochure, pamphlet) to all members in case management meets the intent of this factor.

Factor 7: **Evaluation of cultural and linguistic needs**

Complex case management policies and procedures specify a process for assessing culture and language to identify potential barriers to effective communication or care and acceptability of specific treatments. Policies and procedures also include consideration of cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Factor 8: **Evaluation of visual and hearing needs**

Complex case management policies and procedures specify a process for assessing vision and hearing to identify potential barriers to effective communication or care.

Factor 9: **Evaluation of caregiver resources**

Complex case management policies and procedures specify a process for assessing the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation.

Factor 10: **Evaluation of available benefits**

Complex case management policies and procedures specify a process for assessing the adequacy of health benefits regarding the ability to fulfill a treatment plan. Assessment includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

Factor 11: Evaluation of community resources

Complex case management policies and procedures specify a process for assessing eligibility for community resources that supplement those for which the organization has been contracted to provide, at a minimum:

- Community mental health.
- Transportation.
- Wellness organizations.
- Palliative care programs.
- Nutritional support.

Factor 12: Individual case management plan and goals

Complex case management policies and procedures specify a process for creating a personalized case management plan that meets member needs and includes:

- Prioritized goals.
  - Prioritized goals consider member and caregiver needs and preferences; they may be documented in any order, as long as the level of priority is clear.
- Time frames for reevaluation of goals.
  - Time frames are specified in the case management plan.
- Resources to be utilized, including appropriate level of care.
- Planning for continuity of care, including transition of care and transfers between settings.
- Collaborative approaches to be used, including level of family participation.

Factor 13: Identification of barriers

Complex case management policies and procedures to a member receiving or participating in a case management plan. A barrier analysis can assess:

- Language or literacy level.
- Access to reliable transportation.
- Understanding of a condition.
- Motivation.
- Financial or insurance issues.
- Cultural or spiritual beliefs.
- Visual or hearing impairment.
- Psychological impairment.

The organization documents that it assessed barriers, even if none were identified.

Factor 14: Referrals to available resources

Complex case management policies and procedures specify a process for facilitating referral to other health organizations, when appropriate.

Factor 15: Follow-up schedule

Case management policies and procedures have a follow-up process that includes determining if follow-up is appropriate or necessary (for example, after a member is referred to a disease management program or health resource). The case management plan contains a schedule for follow-up that includes, but is not limited to:

- Counseling.
- Follow-up after referral to a DM program.
- Follow-up after referral to a health resource.
- Member education.
- Self-management support.
- Determining when follow-up is not appropriate.

Factor 16: **Development and communication of self-management plans**

Complex case management policies and procedures specify a process for communicating the self-management plan to the member or caregiver (i.e., verbally, in writing). Self-management plans are activities that help members manage a condition and are based on instructions or materials provided to them or to their caregivers.

Factor 17: **Assessing progress**

Complex case management policies and procedures specify a process for assessing progress toward overcoming barriers to care and to meeting treatment goals, and for assessing and adjusting the care plan and its goals, as needed.

Exceptions

None.

Examples

Factor 3: **Activities of daily living**

- Grooming.
- Dressing.
- Bathing.
- Toileting.
- Eating.
- Transferring (e.g., getting in and out of chairs).
- Walking.

Factor 4: **Cognitive functioning assessment**

- Alert/oriented, able to focus and shift attention, comprehends and recalls direction independently.
- Requires prompting (cuing, repetition, reminders) only under stressful situations or unfamiliar conditions.
- Requires assistance and some direction in specific situation (e.g. on all tasks involving shifting attention) or consistently requires low stimulus environment due to distractibility.
- Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state or delirium.

Factor 5: **Social determinants of health**

- Current housing and housing security.
- Access to local food markets.
- Exposure to crime, violence and social disorder.

- Residential segregation and other forms of discrimination.
- Access to mass media and emerging technologies.
- Social support, norms and attitudes.
- Access, transportation and financial barriers to obtaining treatment.

***Factor 7:* Cultural needs, preferences or limitations**

- Health care treatments or procedures that are discouraged or not allowed for religious or spiritual reasons.
- Family traditions related to illness, death and dying.
- Health literacy assessment.

***Factor 9:* Caregiver assessment**

- Member is independent and does not need caregiver assistance.
- Caregiver currently provides assistance.
- Caregiver needs training, supportive services.
- Caregiver is not likely to provide assistance.
- Unclear if caregiver will provide assistance.
- Assistance needed but no caregiver available.

***Factor 10:* Assessment of available benefits**

- Benefits covered by the organization and by providers.
- Services carved out by the purchaser.
- Services that supplement those the organization has been contracted to provide, such as:
  - Community mental health.
  - Medicaid.
  - Medicare.
  - Long-term care and support.
  - Disease management organizations.
  - Palliative care programs.

***Factor 13:* Assessment of barriers**[2]

- Does the member understand the condition and treatment?
- Does the member want to participate in the case management plan?
- Does the member believe that participation will improve health?
- Are there financial or transportation limitations that may hinder the member from participating in care?
- Does the member have the mental and physical capacity to participate in care?

***Factor 16:* Self-management**

- Self-management includes ensuring that the member can:
  - Perform activities of daily living (e.g., transfer/ambulation, bathing, dressing, toileting, eating/feeding).
  - Perform instrumental activities of daily living (e.g., meals, housekeeping, laundry, telephone, shopping, finances).

[2]Lorig, K. 2001. *Patient Education, A Practical Approach*. Thousand Oaks, CA: Sage Publications. 186–92.

- Self-administer medication (e.g., oral, inhaled or injectable).
- Self-administer medical procedures/treatments (e.g., change wound dressing).
- Manage equipment (e.g., oxygen, IV/infusion equipment, enteral/ parenteral nutrition, ventilator therapy equipment or supplies).
- Maintain a prescribed diet.
- Chart daily weight, blood sugar.

Element D: Initial Assessment—*Refer to Appendix 1 for points*

An NCQA review of a sample of the organization's complex case management files demonstrates that the organization follows its documented processes for:

1. **Initial assessment of member health status, including condition-specific issues.**
2. **Documentation of clinical history, including medications.**
3. **Initial assessment of the activities of daily living (ADL).**
4. **Initial assessment of behavioral health status, including cognitive functions.**
5. **Initial assessment of social determinants of health.**
6. **Evaluation of cultural and linguistic needs, preferences or limitations.**
7. **Evaluation of visual and hearing needs, preferences or limitations.**
8. **Evaluation of caregiver resources and involvement.**
9. **Evaluation of available benefits.**
10. **Evaluation of available community resources.**
11. **Assessment of life-planning activities.**

Scoring

100%	80%	50%	20%	0%
High (90-100%) on file review for 10-11 factors and medium (60-89%) on no more than 1 factor	High (90-100%) on file review for at least 7 factors and medium (60-89%) on file review for the remainder	At least medium (60-89%) on file review for 11 factors	Low (0-59%) on file review for 1-6 factors	7 or more factors in the low range (0-59%)

Data source

Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

Documentation to meet the factors includes evidence that the assessments were completed and documented results of each assessment. A checklist of assessments without documentation of results does not meet the requirement.

Assessment components may be completed by other members of the care team and with the assistance of the member's family or caregiver. Assessment results for each factor must be clearly documented in case management notes, even if a factor does not apply.

If the member is unable to communicate because of infirmity, assessment may be completed by professionals on the care team, with assistance from the patient's family or caregiver.

If case management stops when a member is admitted to a facility and the stay is longer than 30 calendar days, a new assessment must be performed after discharge if the member is identified for case management.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Assessment and evaluation

Assessment and evaluation each require that the case manager or other qualified individual draw and document a conclusion about data or information collected. It is not sufficient to just have raw data or answers to questions. There is a documented summary of the meaning or implications of that data or information to the member's situation, so that it can be used in the case management plan.

Timeliness of assessment

The organization begins the initial assessment within 30 calendar days of identifying a member for complex case management and completes it within 60 calendar days of identification. If the initial assessment was started after the first 30 calendar days of member identification, NCQA scores only factor 1 "No"; the remaining factors are not marked down for starting after the first 30 calendar days of identification.

Additionally, NCQA scores any factor for which the initial assessment is completed more than 60 calendar days from member identification "No", unless the delay was due to circumstances beyond the organization's control:

- The member is hospitalized during the initial assessment period.
- The member cannot be contacted or reached through telephone, letter, email or fax.
- Natural disaster.
- The member is deceased.

The organization documents the reasons for the delay and actions it has taken to complete the assessment.

The assessment may be derived from care or encounters occurring up to 30 calendar days prior to determining identification, if the information is related to the current episode of care (e.g., health history taken as part of disease management or during a hospitalization).

Members are considered eligible upon identification unless they subsequently opt out or additional information reveals them to be ineligible.

Excluded files from review

The organization excludes files from review that meet the following criteria:

- Eligible members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA confirms that the files met the criteria for an NA score.

***Factor 1:* Initial assessment of members' health status**

The file or case record documents a case manager's assessment of the member's current health status, including:

- Information on presence or absence of comorbidities and their current status.
- Self-reported health status.
- Information on the event or diagnosis that led to identification for complex case management.
- Current medications, including dosages and schedule.

***Factor 2:* Documentation of clinical history**

The file or case record contains information on the member's clinical history, including:

- Past hospitalization and major procedures, including surgery.
- Significant past illnesses and treatment history.
- Past medications, including schedules and dosages.

***Factor 3:* Initial assessment of activities of daily living**

The file or case record documents the results of the ADL assessment.

For ADLs with which the member needs assistance, the type of assistance and reason for need of assistance is recorded. The case manager does not need to describe ADLs the member does not need assistance with.

If the member does not need assistance with any ADLs, the case file or case notes reflect that no assistance is needed (e.g., "Member is fully independent with ADLs").

***Factor 4:* Initial assessment of behavioral health status**

The file or case record documents a case manager's assessment of:

- Cognitive functions.
  - The member's ability to communicate and understand instructions.
  - The member's ability to process information about an illness.
- Mental health conditions.
- Substance use disorders.

***Factor 5:* Initial assessment of social determinants of health**

The case manager assesses social determinants of health, which are economic and social conditions that affect a wide range of health, functioning and quality-of-life outcomes and risks that may affect a member's ability to meet goals.

Because social determinants of health are a combination of influences, the organization considers more than one social determinant of health, for a comprehensive overview of the member's health.

***Factor 6:* Evaluation of cultural and linguistic needs**

The file or case record documents a case manager's evaluation of the member's culture and language needs and their impact on communication, care or acceptability of specific treatments. At a minimum, the case manager evaluates:

- Cultural health beliefs and practices.
- Preferred languages.

***Factor 7:* Evaluation of visual and hearing needs**

The file or case record documents a case manager's evaluation of the member's vision and hearing. The document describes specific needs to consider in the case management plan and barriers to effective communication or care.

***Factor 8:* Evaluation of caregiver resources**

The file or case record documents a case manager's evaluation of the adequacy of caregiver resources (e.g., family involvement in and decision making about the care plan) during initial member evaluation. Documentation describes the resources in place and whether they are sufficient for the member's needs, and notes specific gaps to address.

***Factor 9:* Evaluation of available benefits**

The file or case record documents a case manager's evaluation of the adequacy of the member's health insurance benefits in relation to the needs of the treatment plan. The evaluation goes beyond checking insurance coverage; it includes a determination of whether the resources available to the member are adequate to fulfill the treatment plan.

***Factor 10:* Evaluation of community resources**

The file or case record documents a case manager's evaluation of the member's eligibility for community resources and the availability of those resources and documents which the member may need.

For the community resources the member needs, the availability and member's eligibility is also recorded in the file. The case manager does not need to address community resources the member does not need.

If no community resources are needed by the member, the case file or case notes reflect that no community resources are needed (e.g., "Member does not need any of the available community resources").

Factor 11: **Initial assessment of life planning activities**

The file or case record documents a case manager's assessment of whether the member has in place or has considered the need for wills, living wills or advance directives, Medical or Physician Orders of Life-Sustaining Treatment (MOLST or POLST) forms and health care powers of attorney.

If life planning activities are determined to be appropriate, the case manager documents what activities the member has taken and what documents are in place. If determined not to be appropriate, the case manager documents the reason in the case management record or file.

Documentation that the organization provided life-planning information (e.g., brochure, pamphlet) to all members in complex case management meets the intent of this requirement.

Exceptions

None.

Examples None.

Element E: Case Management: Ongoing Management—*Refer to Appendix 1 for points*

The NCQA review of a sample of the organization's complex case management files that demonstrates that the organization follows its documented processes for:

1. **Development of case management plans that include prioritized goals, that take into account member and caregiver goals, preferences and desired level of involvement in the complex case management program.**
2. **Identification of barriers to meeting goals and complying with the case management plan.**
3. **Development of schedules for follow-up and communication with members.**
4. **Development and communication of member self-management plans.**
5. **Assessment of progress against case management plans and goals, and modification as needed.**

Scoring

100%	80%	50%	20%	0%
High (90%-100%) on file review for all 5 factors	High (90%-100%) on file review for at least 3 factors and low (0-59%) on 0 factors	At least medium (60-89%) on file review for 5 factors	Low (0-59%) on file review for no more than 2 factors	3 or more factors in the low range (0-59%)

Data source Records or files

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews initial assessments in a random sample of up to 40 complex case management files. Files are selected from active or closed cases that were opened during the look-back period and remained open for at least 60 calendar days during the look-back period, from the date when the member was identified for complex case management.

The organization must provide the identification date for each case in the file universe.

Look-back period

For First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

Each case file contains evidence that the organization completed the five factors listed, according to its complex case management procedures specified in Element C.

Dispute of file review results

Onsite file review is conducted in the presence of the organization's staff. The survey team works to resolve disputes that arise during the onsite survey. In the event that a dispute cannot be resolved, the organization must contact NCQA before the end of the onsite survey. File review results may not be disputed or appealed once the onsite survey is complete.

Excluded files from review

The organization excludes files from review that meet these criteria:

- Identified members whom it cannot locate or contact after three or more attempts across a 2-week period, within the first 30 calendar days after identification, through at least two of the following mechanisms:
  - Telephone.
  - Regular mail.
  - Email.
  - Fax.
- Members in complex case management for less than 60 calendar days during the look-back period.
  - The organization provides evidence that the patient was identified less than 60 calendar days before the look-back period.

Files that meet these criteria and are inadvertently included in the organization's file review are scored NA for all factors.

NCQA reserves the right to confirm that the files met the criteria for an NA score.

***Factor 1:* Case management plans and goals**

The organization documents a plan for case management that is specific to the member's situation and needs, and includes goals that reflect issues identified in the member assessment and the supporting rationale for goal selection. Goals are specific, measurable and timebound. To be timebound, each goal must have a target completion date.

Case management goals are prioritized. The organization prioritizes goals using high/low, numeric rank or other similar designation. Priorities reflect input from the member or a caregiver, demonstrating the member or caregiver's preferences and priorities. Designating goals as long-term or short-term is not sufficient to meet the requirement. The organization must rank or prioritize goals.

***Factor 2:* Identification of barriers**

Barriers are related to the member or to the member's circumstances, not to the CCM process. The organization documents barriers to the member meeting the goals specified in the CCM plan.

***Factor 3:* Follow-up and communication with members**

The organization documents the next scheduled contact with the member, including the scheduled time or time frame and method, which may be an exact date or relative (e.g., "in two weeks").

***Factor 4:* Self-management plan**

A self-management plan includes actions the member agrees to take to manage a condition or circumstances. The organization documents that the plan has been communicated to the member. Communication may be verbal or written. Documentation includes the member's acknowledgment of and agreement to expected actions.

***Factor 5:* Assessment of progress**

The organization documents the member's progress toward goals. If the member does not demonstrate progress over time, the organization reassesses the applicability of the goals to the member's circumstances and modifies the goals, as appropriate.

Exceptions

None.

Examples ***Factors 1–5:* Case Management—Ongoing Management**

<table>
<tr><td colspan="2">Member Diagnosis: Severe mental illness (depression); chronic homelessness (unstable housing for 8 months)</td></tr>
<tr><td>Identification date: 1/5/2018</td><td>Initial Assessment Completed: 1/30/2018</td></tr>
<tr><td>Goal 1:</td><td>Secure stable housing for member by 2/11/2018. (Factor 1)</td></tr>
<tr><td colspan="2">Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. (Factor 1)

Strategies to achieve goal: Referral to community housing resources; secure temporary safe housing, pending a more permanent solution; accompany member to housing services.

Barriers to goal: Member was previously evicted from temporary shelter due to unwillingness to comply with shelter staff rules. (Factor 2)

Progress assessment: Member moved out of initial temporary shelter because he felt his belongings were unsafe. Asked for help getting into a home where he can lock up his belongings. CM adjusted completion date to 2/21/2018 and investigated group housing. (Factor 5)</td></tr>
<tr><td>Goal 1 completed:</td><td>2/16/2018.
Note: Member was accepted into adult male group housing, once he understood and accepted house rules, is comfortable with secure locker for belongings. (Factor 5)</td></tr>
</table>

Goal 2:	• Improve member's Patient Health Questionnaire-9 (PHQ-9) score from baseline (23 at initial assessment 1/30/2018) over 3–6 months. • Improve 5 points from baseline by 4/30/2018. • Improve 11 points from baseline by 7/30/2018. **(Factor 1)**
Goal case notes: Member did not identify a family or friend caregiver. Member expresses a desire for a home and is willing to accept case manager's help to manage other conditions, once in stable housing. Member feels that stable housing will help depression and is willing to attend therapy sessions. **(Factor 1)** *Strategies to achieve goal:* Implement a reminder system for taking medications; arrange transportation for therapist visits; check in weekly to discuss progress. *Barriers to goal:* Member uncertain about how to get to therapy sessions and states that he feels overwhelmed by having to change buses and remember schedules. Member said his medication has been stolen in shelters before. **(Factor 2)** *Progress assessment:* Member feels his medications are safe in group home lockers. CM helped the member set up a calendar pill case and clock alarm as medication reminders. CM arranged van transportation to twice weekly therapy sessions. CM assessed PHQ score at weekly call on 4/28/2018. Score was 16 (9 less than baseline). Member stated that housing greatly improved depression. Therapy sessions adjusted to weekly. CM assessed PHQ score at weekly call on 7/28/2018. Score was 12 (11 less than baseline). **(Factor 5)**	
Goal 2 completed:	7/28/2018. ***Note:*** *Member attends therapy. Member can navigate bus lines without anxiety; assisted transportation to sessions discontinued.* **(Factor 5)**
Follow-up and communication plan:	CM scheduled weekly follow-up calls at 5pm on Fridays via the group home's phone line. CM gave member direct emergency line and is working to secure cell phone for member. **(Factor 3)**
Self-management plan:	• Member will attend weekly follow-up calls on Fridays at 5pm via ***-***-****. • Member will continue to follow rules of group home. • Member will alert CM if changes to housing occur. • Member will use alarm clock reminders to take medication on schedule. Member and CM will discuss monthly refills to medications box. • CM arranges medication to be mailed to group home; member agrees to verify medication with CM during weekly calls. • Member attends therapy sessions and alerts group home staff to dramatic changes in mood (e.g., suicidal ideation). • Member will work with group home staff and other residents to learn bus routes and how to change buses on route. **(Factor 4)** ***Note*****:** *Member signed and has copies of the agreed-on self-management and case management plans. Signed copies attached.* **(Factor 4)**

Element F: Experience With Case Management—*Refer to Appendix 1 for points*

At least annually, the organization evaluates experience with its complex case management program by:

1. Obtaining feedback from members.

2. Analyzing member complaints.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	The organization meets 1 factor	No scoring option	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys. For First Surveys: NCQA reviews the organization's most recent annual data collection and evaluation report.

For Renewal Surveys: During the most recent year, the organization obtains and analyzes member feedback about:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

During the previous year, the organization obtains and analyzes member feedback about:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 24 months; at least once during the prior year for the percentage of members component of factor 1.

Explanation

***Factor 1:* Analyzing member feedback**

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the complex case management programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may assess the entire population or draw statistically valid samples.

If the organization uses a sample, it describes the sample universe and the sampling methodology.

If satisfaction surveys are conducted at the corporate or regional level, results are stratified at the accreditable entity level for analysis and to determine actions. CAHPS and other general survey questions do not meet the intent of this element.

The organization conducts a quantitative data analysis to identify patterns in member feedback, and conducts a causal analysis if it did not meet stated goals.

Factor 2: **Analyzing member complaints**

The organization analyzes complaints to identify opportunities to improve satisfaction with its complex case management program.

Exceptions

None.

Examples

Member feedback questions

1. Did the case manager help you understand the treatment plan?
2. Did the case manager help you get the care you needed?
3. Did the case manager pay attention to you and help you with problems?
4. Did the case manager treat you with courtesy and respect?
5. How satisfied are you with the case management program?

Table 1: Annual complex case management member satisfaction survey results (N = Number of respondents)

How Satisfied Are You…?	Very Satisfied		Satisfied		Combined		Sample Size	90% Goal Met?
	N	%	N	%	N	%		
With how the case manager helped you understand the doctor's treatment plan	75	60%	25	20%	100	80%	125	No
With how the case manager helped you get the care you needed	80	64%	35	28%	115	92%	125	Yes
With the case manager's attention and help with problems	70	56%	45	36%	1151	92%	125	Yes
With how the case manager treated you	85	68%	35	28%	120	96%	125	Yes

The Complex Case Management Team and the QI staff conducted a root cause analysis of the areas where goals were not met.

Table 2: Member feedback qualitative analysis

Root Cause/Barrier	Opportunity for Improvement	Prioritized for Action? (Y/N)
Members do not understand the treatment plan	Case managers identify health literacy issues and member preferences for information early in the case management process	Y

Complaints

- Limited access to case manager.
- Dissatisfaction with case manager.
- Timeliness of case management services.

Table 3: Complaint volume

Complex Case Management Complaints	Q1	Q2	Q3	Q4	Total 2019	Total 2018
Access to case manager	2	0	0	1	3	4
Dissatisfaction with case manager	1	2	0	1	4	5
Timeliness of case management services	1	0	2	2	5	5
Inquiries	3	1	2	4	10	12
Total case management	7	3	4	8	22	26

Findings

There were 22 complex case management complaints in 2019; there were 26 in 2018. Totals by category were also lower in 2019 than in 2018. Given the volume of cases over the past year, the numbers and types of complaints do not present opportunities for improvement.

The organization will continue to track and trend complaints and grievances annually, and compare results with the previous year's performance.

PHM 6: Population Health Management Impact
—Refer to Appendix 1 for points

The organization measures the effectiveness of its PHM strategy.

Intent

The organization has a systematic process to evaluate whether it has achieved its goals and to gain insights into areas needing improvement.

Summary of Changes

Clarifications

- Added "reports" as a data source and revised the look-back period for First and Renewal surveys to at least once during the prior year (Element A).
- Revised the Explanation for *factor 3 (interpretation of results)* (Element A).
- Revised the look-back period for First and Renewal Surveys to at least once during the prior year (Element B).
- Deleted the exception that reads, "This element is NA for 2018" (Element B).

Element A: Measuring Effectiveness—*Refer to Appendix 1 for points*

At least annually, the organization conducts a comprehensive analysis of the impact of its PHM strategy that includes the following:

1. Quantitative results for relevant clinical, cost/utilization and experience measures.

2. Comparison of results with a benchmark or goal.

3. Interpretation of results.

Scoring

100%	80%	50%	20%	0%
The organization meets all 3 factors	No scoring option	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Documented process, Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys: NCQA reviews the organization's plan for its annual comprehensive analysis of PHM strategy impact. NCQA also reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: At least once in the prior year.

Explanation

This element is a structural requirement. The organization must present its own materials.

The organization conducts an annual comprehensive, quantitative, analysis of the impact of the organization's PHM strategy.

***Factor 1:* Quantitative results**

Relevant measures align with the areas of focus, activities or programs as described in PHM 1, Element A. The organization describes why measures are relevant. Measures may focus on one segment of the population or on populations across the organization.

Clinical measures

Measures can be activities, events, occurrences or outcomes for which data can be collected for comparison with a threshold, benchmark or prior performance. Clinical measures may be:

1. *Outcome measures:* Incidence or prevalence rates for desirable or undesirable heath status outcomes (e.g., infant mortality), ***or***
2. *Process measures:* Measures of clinical performance based on objective clinical criteria defined from practice guidelines or other clinical specifications (e.g., immunization rates).

Cost/Utilization measures

Utilization is an unweighted count of services (e.g., inpatient discharges, inpatient days, office visits, prescriptions). Utilization measures capture the frequency of services provided by the organization. Cost-related measures can be used to demonstrate utilization. The organization measures cost, resource use or utilization.

Cost of care considers the mix and frequency of services, and is determined using actual unit price per service or unit prices found on a standardized fee schedule. Examples of cost of care measurement include:

- Dollars per episode, overall or by type of service.
- Dollars per member, per month (PMPM), overall or by type of service.
- Dollars per procedure.

Resource use considers the cost of services in addition to the count of services across the spectrum of care, such as the difference between a major surgery and a 15-minute office visit.

Experience

The organization obtains and analyzes member feedback, using focus groups or satisfaction surveys. Feedback is specific to the programs being evaluated and covers, at a minimum:

- Information about the overall program.
- The program staff.
- Usefulness of the information disseminated.
- Members' ability to adhere to recommendations.
- Percentage of members indicating that the program helped them achieve health goals.

The organization may also analyze complaints to identify opportunities to improve satisfaction.

The organization analyzes feedback from at least two types of programs. The organization may use its complex case management member experience results and member experience results from one other program or service (e.g., disease management program or wellness program).

CAHPS and other general survey questions do not meet the intent of this element.

Factor 2: **Comparison of results**

The organization performs quantitative data analysis that compares results with an established, explicit and quantifiable goal or benchmark. Analysis includes past performance, if a previous measurement was performed.

Tests of statistical significance are not required, but may be useful when analyzing trends.

Factor 3: **Interpretation of results**

Measures are assessed together to provide a comprehensive analysis of the effectiveness of the PHM strategy. Interpretation is more than simply a presentation of results; it gives the organization insight into its PHM programs and strategy, and helps it understand the programs' effectiveness and impact on areas of focus. The organization conducts a qualitative analysis if stated goals are not met.

Note:

- *Participation rates do not qualify for this element.*
- *If the organization uses SF-8®, SF-12® or SF-36® to measure health status, results may count for two measures of effectiveness: one each for physical and mental health functioning.*

Exceptions

None.

Examples

Factor 1

Utilization includes measures of waste, overutilization, access, cost or underutilization.

Experience

- Patient Health Questionnaire (PHQ-9).
- Patient-Reported Outcomes Measurement Information System (PROMIS) tools.
- Program-specific surveys.

Element B: Improvement and Action—*Refer to Appendix 1 for points*

The organization uses results from the PHM impact analysis to annually:

1. Identify opportunities for improvement.

2. Act on one opportunity for improvement.

Scoring

100%	80%	50%	20%	0%
The organization meets 2 factors	No scoring option	The organization meets 1 factor	No scoring option	The organization meets 0 factors

Data source

Reports

Scope of review

This element applies to First Surveys and Renewal Surveys.

For First and Renewal Surveys: NCQA reviews the organization's most recent annual comprehensive analysis of PHM strategy impact.

NCQA reviews this element for each product line brought forward for accreditation. The score for the element is the average of the scores for all product lines.

Look-back period

For First Surveys and Renewal Surveys: At least once during the prior year.

Explanation

This element is a structural requirement. The organization must present its own materials.

Factor 1: **Opportunities for improvement**

The organization uses the results of its analysis to identify opportunities for improvement, which may be different each time data are measured and analyzed. NCQA does not prescribe a specific number of improvement opportunities.

Factor 2: **Act on opportunity for improvement**

The organization develops a plan to act on at least one identified opportunity for improvement.

Exceptions

None.

Examples

None.

PHM 7: Delegation of PHM—*Refer to Appendix 1 for points*

If the organization delegates NCQA-required PHM activities, there is evidence of oversight of the delegated activities.

Intent

The organization remains responsible for and has appropriate structures and mechanisms to oversee delegated PHM activities.

Summary of Changes

Clarifications

- Element B: Provision of Member Data to the Delegate is now factor 5 in Element A: Delegation Agreement (Elements A).
- Revised the look-back period for new requirements for Renewal Surveys to 12 months from 6 months (Elements A, B, D).
- Revised the look-back period to from 6 months to 12 months for Renewal Surveys (Element B).
- Revised the use of collaborative language in the Related information (Element B).
- Added a *Related information* section and the use of collaborative language (Element C).

Deletions

- Eliminated *Element C: Provisions for PHI* and relettered the remaining elements.

Element A: Delegation Agreement—*Refer to Appendix 1 for points*

The written delegation agreement:

1. **Is mutually agreed upon.**
2. **Describes the delegated activities and the responsibilities of the organization and the delegated entity.**
3. **Requires at least semiannual reporting by the delegated entity to the organization.**
4. **Describes the process by which the organization evaluates the delegated entity's performance.**
5. **Describes the process for providing member experience and clinical performance data to its delegates when requested.**
6. **Describes the remedies available to the organization if the delegated entity does not fulfill its obligations, including revocation of the delegation agreement.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 6 factors	The organization meets 5 factors	The organization meets 3-4 factors	The organization meets 1-2 factors	The organization meets 0 factors

Data source Materials

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

NCQA reviews delegation agreements in effect during the look-back period from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

Delegation agreements implemented on or after January 1, 2019, must include a description of the process required in factor 5.

For delegation agreements in place prior to January 1, 2019, the organization may provide documentation that it notified the delegate of the process. This documentation of notification is not required to be mutually agreed upon.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: 6 months.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

This element applies to agreements that are in effect during the look-back period.

The delegation agreement describes all delegated PHM activities. A generic policy statement about the content of delegated arrangements does not meet this element.

***Factor 1:* Mutual agreement**

Delegation activities are mutually agreed on before delegation begins, in a dated, binding document or communication between the organization and the delegated entity.

***Factor 2:* Assigning responsibilities**

The delegation agreement or an addendum thereto or other binding communication between the organization and the delegate specifies the PHM activities:

- Performed by the delegate, in detailed language.
- Not delegated, but retained by the organization.
- The organization may include a general statement in the agreement addressing retained functions (e.g., the organization retains all other PHM functions not specified in this agreement as the delegate's responsibility).

If the delegate subdelegates an activity, the delegation agreement must specify that the delegate or the organization is responsible for subdelegate oversight.

***Factor 3:* Reporting**

The organization determines the method of reporting and the content of the reports, but the agreement must specify:

- That reporting is at least semiannual.
- What information is reported by the delegate about PHM delegated activities.
- How, and to whom, information is reported (i.e., joint meetings or to appropriate committees or individuals in the organization).

The organization must receive regular reports from all delegates, even NCQA-Accredited/Certified delegates.

***Factor 4:* Performance monitoring**

The delegation agreement specifies how the organization evaluates the delegate's performance.

***Factor 5:* Providing member and clinical data**

The organization provides:

- *Member experience data:* Complaints, CAHPS 5.0H survey results or other data collected on members' experience with the delegate's services.
- *Clinical performance data:* HEDIS measures, claims and other clinical data collected by the organization. The organization may provide data feeds for relevant claims data or clinical performance measure results.

***Factor 6:* Consequences for failure to perform**

The delegation agreement specifies consequences if a delegate fails to meet the terms of the agreement and, at a minimum, circumstances that would cause revocation of the agreement.

Exception

This element is NA if the organization does not delegate PHM activities.

Examples None.

Element B: Predelegation Evaluation—*Refer to Appendix 1 for points*

For new delegation agreements initiated in the look-back period, the organization evaluated delegate capacity to meet NCQA requirements before delegation began.

Scoring

100%	80%	50%	20%	0%
The organization evaluated delegate capacity before delegation began	No scoring option	The organization evaluated delegate capacity after delegation began	No scoring option	The organization did not evaluate delegate capacity

Data source Reports

Scope of review

This element applies to Interim Surveys, First Surveys and Renewal Surveys.

This element applies if delegation was implemented in the look-back period.

NCQA reviews the organization's predelegation evaluation for up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim and First Surveys: 6 months.
For Renewal Surveys: 12 months.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Predelegation evaluation

The organization evaluated the delegate's capacity to meet NCQA requirements within 12 months prior to implementing delegation.

NCQA considers the date of the agreement to be the implementation date if the delegation agreement does not include an implementation date.

If the time between the predelegation evaluation and implementation of delegation exceeds the 12 months, the organization conducts another predelegation evaluation.

If the organization amends the delegation agreement to include additional PHM activities within the look-back period, it performs a predelegation evaluation for the additional activities.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for longer than the look-back period.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples

Predelegation evaluation

- Site visit.
- Telephone consultation.
- Documentation review.
- Committee meetings.
- Virtual review.

Element C: Review of PHM Program—*Refer to Appendix 1 for points*

For arrangements in effect for 12 months or longer, the organization:

1. **Annually reviews its delegate's PHM program.**
2. **Annually audits complex case management files against NCQA standards for each year that delegation has been in effect, if applicable.**
3. **Annually evaluates delegate performance against NCQA standards for delegated activities.**
4. **Semiannually evaluates regular reports, as specified in Element A.**

Scoring

100%	80%	50%	20%	0%
The organization meets all 4 factors	The organization meets 3 factors	The organization meets 2 factors	The organization meets 1 factor	The organization meets 0 factors

Data source

Reports

Scope of review

Factor 1 applies to Interim Surveys, First Surveys and Renewal Surveys.

All factors in this element apply to First Surveys and Renewal Surveys.

NCQA reviews a sample from up to four randomly selected delegates, or reviews all delegates if the organization has fewer than four.

For Interim Surveys: NCQA reviews the organization's review of the delegate's PHM program.

For First Surveys: NCQA reviews the organization's most recent annual review, audit, performance evaluation and semiannual evaluation.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews, audits, performance evaluations and four semiannual evaluations

The score for the element is the average of the scores for all delegates.

Look-back period

For Interim Surveys and First Surveys: Once during the prior year.

For Renewal Surveys: Once during the prior year for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA scores factor 2 and 3 "yes" if all delegates are NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

***Factor 1:* Review of the PHM program**

Appropriate organization staff or committee reviews the delegate's PHM program. At a minimum, the organization reviews parts of the PHM program that apply to the delegated functions.

Factor 2: **Annual file audit**

If the organization delegates complex case management, it audits the delegate's complex case management files against NCQA standards. The organization uses either of the following to audit the files:

- 5 percent or 50 of its files, whichever is less.
- The NCQA "8/30 methodology" available at http://www.ncqa.org/Programs/Accreditation/PolicyUpdatesSupportingDocuments.aspx

The organization bases its annual audit on the responsibilities described in the delegation agreement and the appropriate NCQA standards.

Factor 3: **Annual evaluation**

No additional explanation required.

Factor 4: **Evaluation of reports**

No additional explanation required.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.

Factor 2 is NA if the organization does not delegate complex case management activities.

Factors 2–4 are NA for Interim Surveys.

Related information

Use of collaboratives. The organization may enter into a statewide collaboration to perform any or all of the following:

- Predelegation evaluation.
- Annual evaluation.
- Annual audit of files.

The collaborative must agree on the use of a consistent audit tool and must share data. Each organization is responsible for meeting NCQA delegation standards, but may use the shared data collection process to reduce burden.

Examples None.

Element D: Opportunities for Improvement—*Refer to Appendix 1 for points*

For delegation arrangements that have been in effect for more than 12 months, at least once in each of the past 2 years that delegation has been in effect, the organization identified and followed up on opportunities for improvement, if applicable.

Scoring

100%	80%	50%	20%	0%
At least once in each of the past 2 years that the delegation arrangement has been in effect, the organization has acted on identified problems, if any	No scoring option	The organization has taken inappropriate or weak action, or has taken action only in the past year	No scoring option	The organization has taken no action on identified problems

Data source

Documented process, Reports, Materials

Scope of review

This element applies to First Surveys and Renewal Surveys.

NCQA reviews reports for opportunities for improvement if applicable from up to four randomly selected delegates, or from all delegates, if the organization has fewer than four, and for evidence that the organization took appropriate action to resolve issues.

For First Surveys: NCQA reviews the organization's most recent annual review and follow-up on improvement opportunities.

For Renewal Surveys: NCQA reviews the organization's most recent and previous year's annual reviews and follow-up on improvement opportunities.

The score for the element is the average of the scores for all delegates.

Look-back period

For First Surveys: At least once during the prior year.

For Renewal Surveys: 12 months for delegated PHM 1, Elements A, B; PHM 2, Elements A–D; PHM 3, Element A; PHM 4, Element C, factor 14; PHM 5, Element C, factors 3, 5, 11; Element D, factor 5; Element F, factor 1 (percentage of members component of the factor); 24 months for all other PHM activities.

Explanation

This element may not be delegated.

NCQA-Accredited/Certified delegates

NCQA scores this element 100% if all delegates are NCQA NCQA-Accredited health plans, MBHOs or CMOs, or are NCQA-Accredited/Certified DMOs, unless the element is NA.

Identify and follow up on opportunities

The organization uses information from its predelegation evaluation, ongoing reports, or annual evaluation to identify areas of improvement.

Exceptions

This element is NA if:

- The organization does not delegate PHM activities.
- Delegation arrangements have been in effect for less than 12 months.
- The organization has no opportunities to improve performance.
  – NCQA evaluates whether this conclusion is reasonable, given assessment results.

Examples None.

Proposed Population Health Management (PHM) Strategy Overview

Special Board of Directors' Quality Assurance Committee Meeting
January 17, 2019

Betsy Ha, RN, MS, Lean Six Sigma Master Black Belt
Executive Director, Quality & Analytics

Agenda

- 2018 National Committee for Quality Assurance (NCQA) Standards Change
- Population Health Management Conceptual Framework
- New Standards Overview
- Timeline and Accomplishments To Date
- Proposed PHM Strategy
- Discussion and Feedback

2018 NCQA Standard Changes

OLD

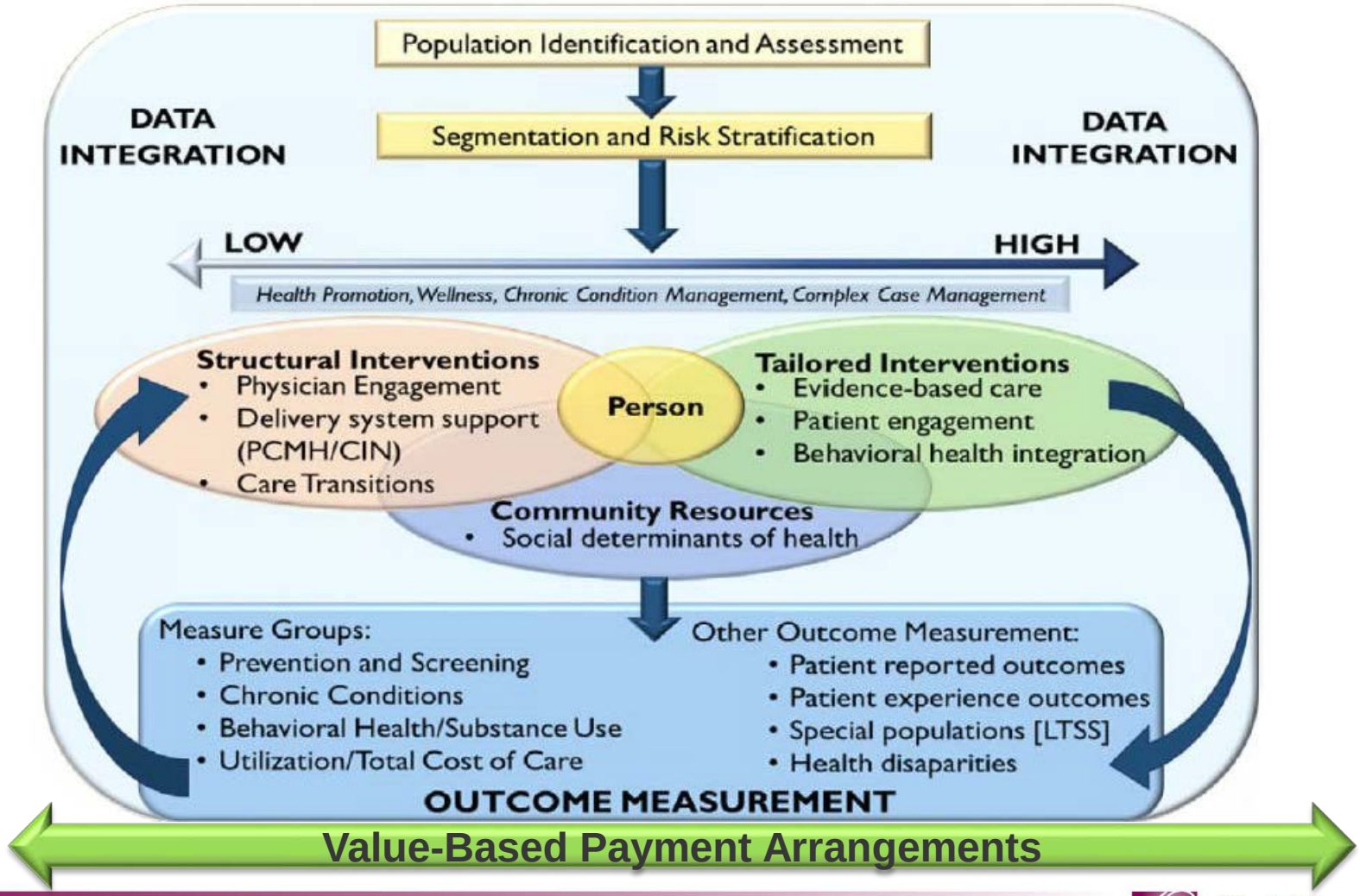
- Quality Improvement (QI) 5 Complex Case Management (CCM)
- QI 6 Disease Management (DM)
- Measuring Effectiveness by Individual Program

NEW

- Created Population Health Management (PHM) Standard Set
- Eliminated DM
- Move CCM under PHM
- Combined Measuring Effectiveness
- Added Standards
  - Data Integration
  - Delivery System Support

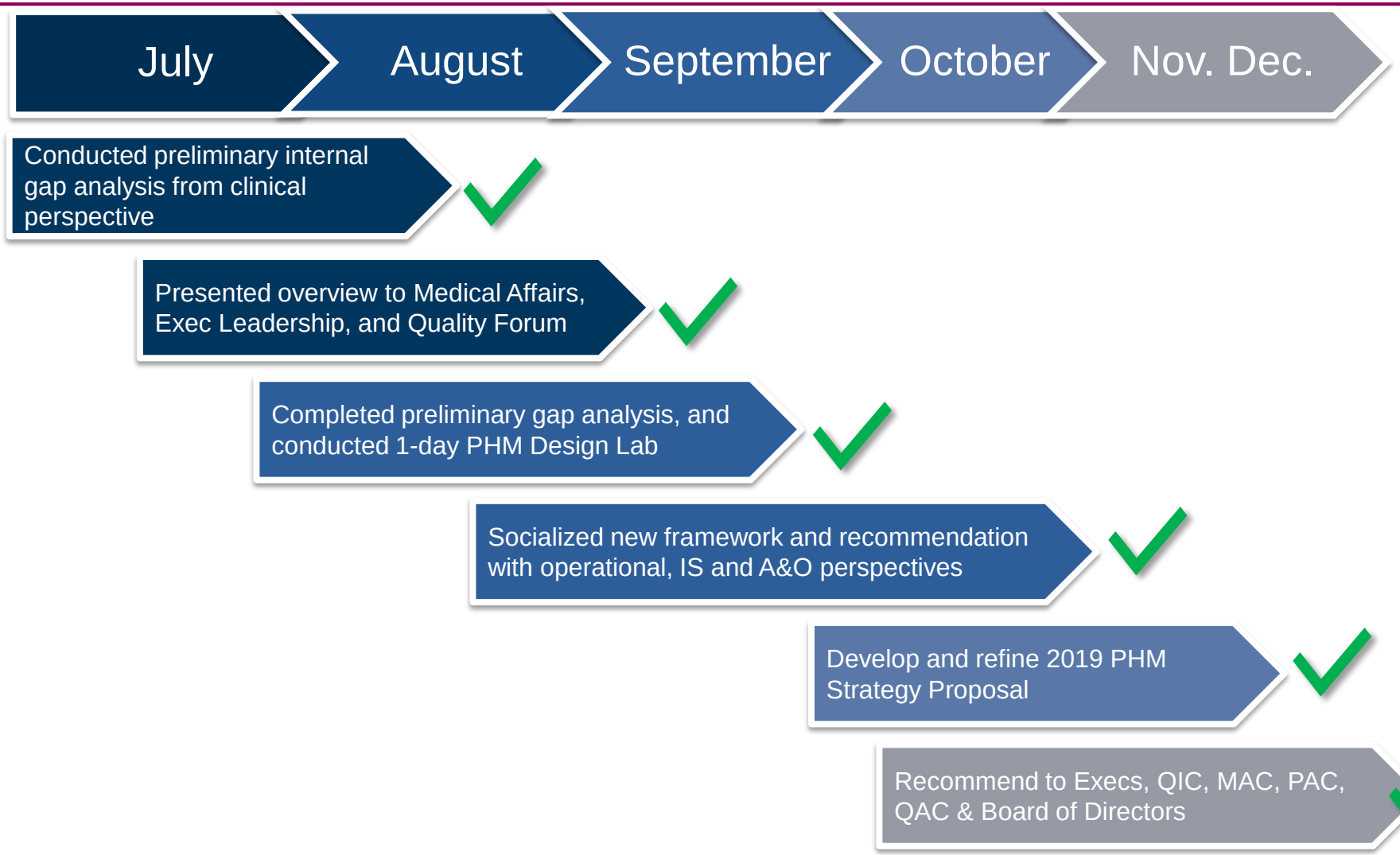
PHM Conceptual Framework

Figure 1.PHM Conceptual Model



Source: Diagram from ACAP presentation 3/29/17

2018 Accomplishments



PHM1 Element A: Strategy
(Effective July 2018)

The organization has a cohesive plan of action for addressing member needs across the continuum of care.

1. Goals and populations targeted for each of the four areas of focus
   - Keeping members healthy
   - Managing members with emerging risk
   - Patient safety or outcomes across settings
   - Managing multiple chronic illnesses
2. Programs or services offered to members
3. **Activities that are not direct member interventions**
4. How member programs are coordinated
5. How members are informed about available PHM programs

Data Source: Documented Process

PHM2 Element A: Data Integration
(Effective July 2018)

The organization assesses the needs of its population and determines actionable categories for appropriate interventions using:

1. Medical and behavioral claims or encounters
2. Pharmacy claims
3. Laboratory results
4. Health appraisal results
5. Electronic health records
6. Health services programs within the organization
7. Advanced data sources

Data source: Documented Process, Reports and Materials

PHM3 Element A: Practitioner or Provider Support (Effective July 2018)

The organization works with practitioners or providers to achieve population health management goals as part of Delivery System Support.

1. Sharing data
2. Offering evidence-based or certified decision-making aids
3. Providing practice transformation support to primary care practitioners
4. Providing comparative quality information on selected specialties
5. Comparative pricing information for selected services
6. One additional activity to support practitioners or providers in achieving PHM goals.

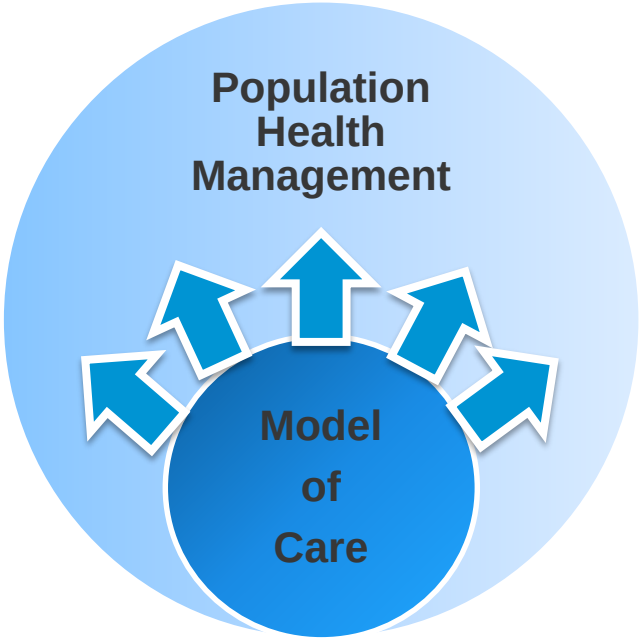
Data source: Documented Process and Materials

PHM1 Four Areas of Focus

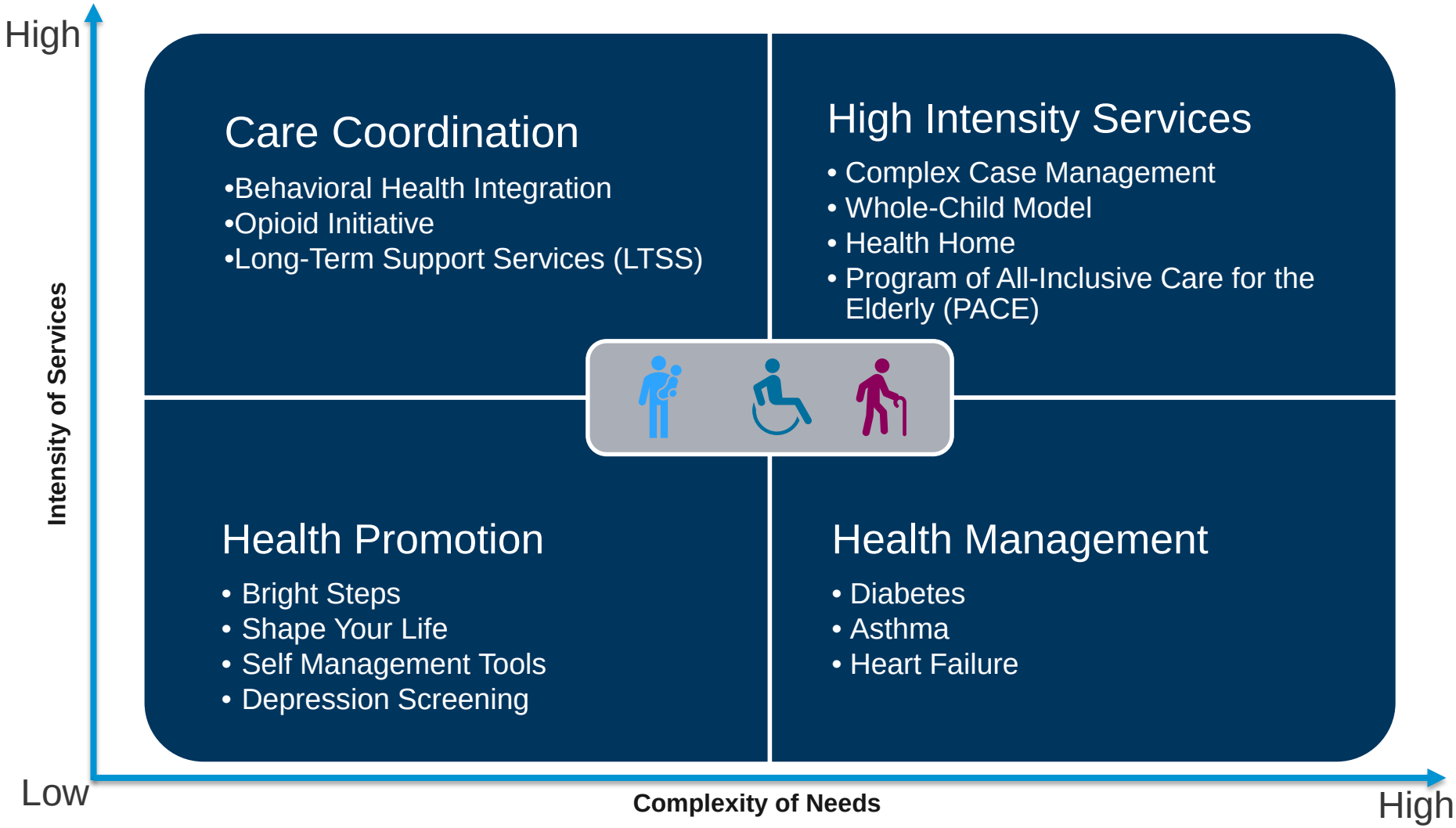
Improving Outcomes Across All Settings

PHM Strategy Intent and Approach

The CalOptima Population Health Management Strategy aims to ensure the care and services provided to our members are delivered in a whole person-centered, safe, effective, timely, efficient, and equitable manner across the entire health care continuum and life span.



Current CalOptima Programs



Keeping Members Healthy

Bright Steps — Improve Prenatal and Postpartum Care

- Goals:
  - Improve 2018 Healthcare Effectiveness Data and Information Set (HEDIS) Prenatal Care rates (83.6%) from the 50th percentile to 75th percentile over a 24-month period.
  - Improve 2018 HEDIS Postpartum Care rates (69.44%) from 75th percentile to 90th percentile over a 24-month period
  - Reduce NICU Days/K
- Target Population:
  - Members in the first trimester of pregnancy
- Description of Programs or Services:
  - Support a healthy pregnancy and postpartum care aligned with the Comprehensive Perinatal Services Program (CPSP) guidelines
- Activities:
  - Member outreach and coordination with CPSP providers
  - Direct health education and support CPSP interventions

Keeping Members Healthy (Cont.)

Shape Your Life — Prevent Childhood Obesity

- Goal:
  - Maintain HEDIS Rates of 90th percentile or greater for Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures year-over-year for the following:
    - BMI Percentile (WCC)
    - Counseling for Nutrition (WCC)
    - Counseling for Physical Activity (WCC)
- Target Population:
  - Members age 5-18 with a Body Mass Index (BMI) equal to/or above the 85th percentile.
- Description of Programs or Services:
  - Health education and physical fitness activity program using evidence-based Kids-N Fitness curriculum conducted in 12 group classes in the community.
- Activities:
  - Active health education and member incentive for follow up visit with PCP after 6 consecutive classes

Managing Members with Emerging Risk

Health Management Programs — Improving Chronic Illness Care

- Goals:
  - Demonstrate significant improvement in 2018 HEDIS measures related to chronic illness management for Asthma Medication Ratio (AMR), Medication Management for People with Asthma (MMA), Monitoring for Patients on Persistent Medications (MPM), Controlling Blood Pressure (CBP) and Comprehensive Diabetes Care (CDC)
  - Increase member satisfaction with program to 90% in 2018
  - Reduce ED and IP rates by 3% for program participants in 2018
- Target population:
  - Members at risk for Asthma, Diabetes and/or Heart Failure

Managing Members with Emerging Risk (cont.)

Health Management Programs — Improving Chronic Illness Care (cont.)

- Description of Programs or Services:
  - Integrated health management and disease prevention programs to improve the health of our members with low acuity to moderate-risk chronic illness requiring ongoing intervention.
- Activities:
  - Member outreach
  - Health education classes
  - Self-management Tools
  - Telephonic coaching
  - Explore Board approval to expand member engagement leveraging virtual technology such as secured telehealth, texting, and remote patient monitoring (New Idea)

Managing Members with Emerging Risk (Cont.)

Opioid Misuse Reduction Initiative — Prevent and Decrease Opioid Addiction

- Goals:
  - Decrease the prevalence of opioid use disorder by implementing a comprehensive pharmacy program by December 2019
  - Decrease Emergency Department utilization related to substance disorder
- Target Population:
  - Members with diagnosis of opioid substance abuse disorder
- Description of Programs or Services:
  - A multi-department and health collaborative aimed at reducing opioid misuse and related death
- Activities:
  - Pharmacy lock-in program
  - Case management outreach
  - Physician academic detailing for safer prescribing
  - Develop access to Medication Assisted Treatment (MAT)

Patient Safety

Behavioral Health Treatment (BHT) Services

- Goal: Establish baseline in 2018
- Target Population:
  - Children with Autism Spectrum Disorder (ASD) who are eligible Medi-Cal members under 21 years of age Early and Periodic Screening, Diagnostic and Treatment (EPSDT) mandate
- Description of Programs or Services:
  - Provide medically necessary BHT services to children with ASD. BHT is the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior.
- Activities:
  - Treatment planning and implementation
  - Direct observation and measurement
  - Functional analysis

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team

- Goal:
  - Achieve and sustain 100% compliance of all Facility Site Review (FSR) audits year-over-year for primary care practices.
- Target Population:
  - Medi-Cal adults and children accessing primary care.
- Description of Programs or Services:
  - Enhancing the existing FSR nursing function by training nurses QI facilitation skills to address any gaps from FSR audit to improve compliance with practice health and safety standards at the practices sites of the CalOptima Community Network (CCN).

Patient Safety — New Idea

Practice Transformation — Improve Practice Health and Safety Leveraging the QI Practice Facilitators Team (cont.)

- Activities:
  - Develop Practice Facilitator function of the existing Facility Site Review (FSR) nurses to identify opportunities to improve practice site health and safety, provide QI technical assistance to these practices to achieve zero defect patient safety at the primary care practices.
  - Provide QI technical support to the safety net community clinics, Federally Qualified Health Center (FQHC), and PACE to promote patient safety practices.

Managing Members with Multiple Chronic Illnesses

Whole Child Model — Ensure Whole-Child Centric Quality and Continuity Care for Children with California Children's Condition (CCS) Eligible Conditions

- Goal:
  - Improve Children and Adolescent Immunization HEDIS measures to ≥ 75th percentile by December 2020 (excluding children and adolescent under cancer treatment)
- Targeted Population:
  - Children with CCS eligible conditions
- Description of Programs or Services:
  - The WCM program is designed to help children receiving CCS services and their families get better care coordination, access to care, and to promote improved health results.
- Activities:
  - Care Management
  - Personal Care Coordinator (PCC)

Managing Members with Multiple Chronic Illnesses (Cont.)

Health Home Program (HHP) Pilot — Improve Clinical Outcomes of Members With Multiple Chronic Conditions and Experiencing Homelessness

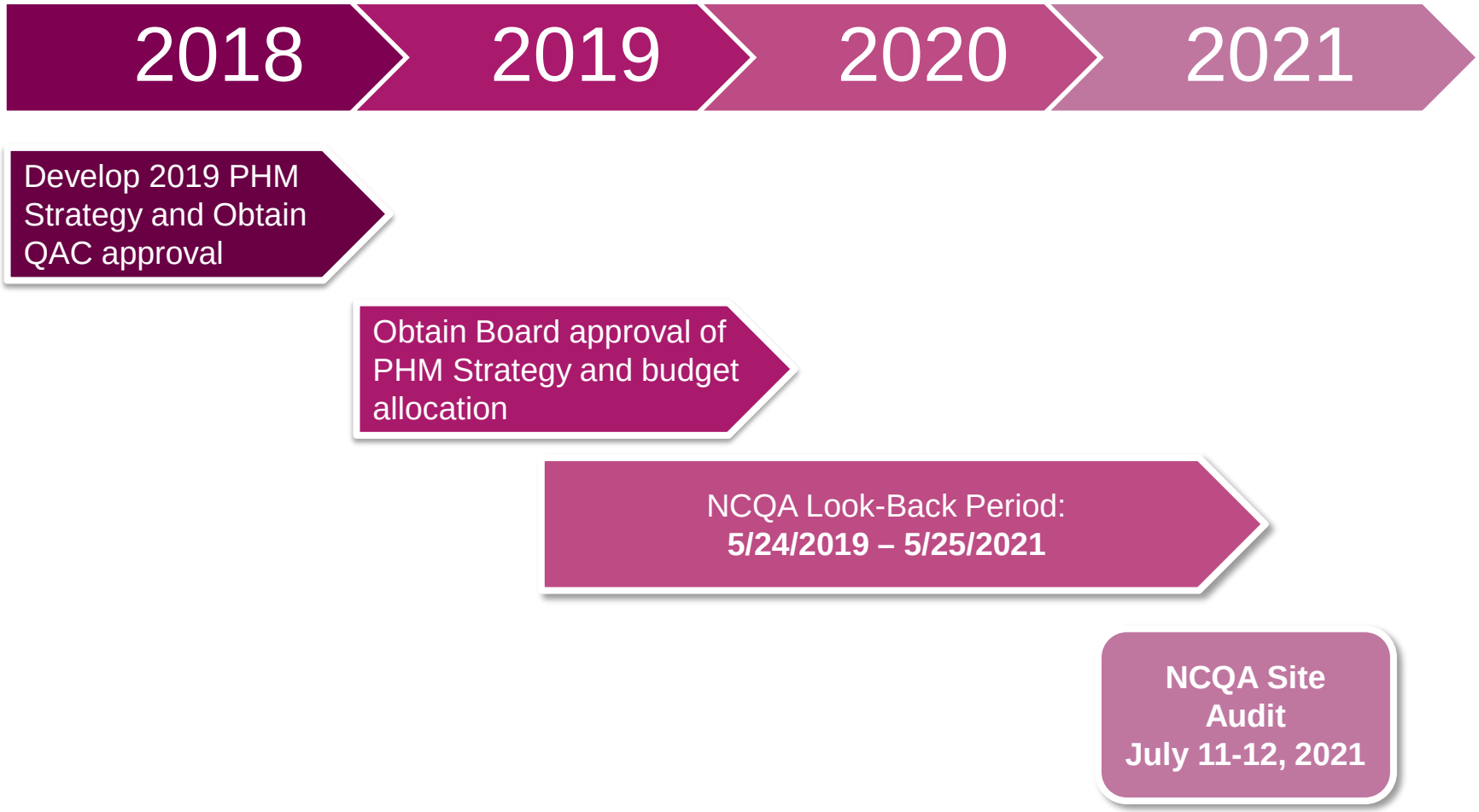
- Goal: Establish baseline in 2019
- Target Population:
  - Highest risk 3-5% of the Medi-Cal members with multiple chronic conditions meeting the following eligible criteria as determined by Department of Health Care Services (DHCS).
- Description of Programs or Services:
  - A pilot program of enhanced comprehensive care management program with wrap-around non-clinical social services for members with multiple chronic conditions and homelessness.
- Activities:
  - High touch core services as defined by DHCS

Delivery System Support (PHM3A)

Delivery System for Practitioner/Provider Support

- Information Sharing
  - Increase actionable data sharing to support academic detailing to improving outcomes across all settings.
- Practice Transformation Technical Assistance (New Idea)
  - Build upon internal FSR and QI capability to offer practice transformation support through Lean QI training, practice site facilitations, and/or individualize technical assistance to improve member experience.
- Provider Coaching (New Idea)
  - Offer individual provider coaching session and office staff workshops to improve quality of services and patient experience to targeted high volume CCN provider practices.

NCQA Timeline



Discussion and Feedback

Attachment 9 to May 7, 2020 Board of Directors Meeting– Agenda Item 8

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Legal Name	Address	City	State	Zip code
mPulse Mobile	16530 Ventura Blvd., Suite 500	Encino	CA	91436

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

17. Approve Modifications to CalOptima Policy GG.1105: Coverage of Organ and Tissue Transplants and GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization

Contacts

Richard Pitts, Chief Medical Officer, (714) 347-5750
Kelly Giardina, Executive Director, Clinical Operations, (657) 900-1013

Recommended Actions

Approval of modifications to the following Utilization Management Policies pursuant to CalOptima's policy review process:

1. Policy GG.1105: Coverage of Organ and Tissue Transplants
2. Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization

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, laws, and CalOptima Operations.

Below is a description of the impacted policies, followed by a list of substantive changes to each policy, which are reflected in the attached redlines. The list does not include non-substantive changes that may also be reflected in the redlines (e.g., formatting, spelling, punctuation, capitalization, minor clarifying language and/or grammatical changes).

1. **Policy GG.1105: Coverage of Organ and Tissue Transplants** outlines transplant coverage for CalOptima Members under the Medi-Cal program to ensure they are medically necessary and are provided at a DHCS approved Centers of Excellence (COE) or a California Children's Services (CCS)-approved Special Care Center for those with a CCS eligible condition. This policy was reviewed to include the requirements of:
   - Department of Health Care Services All Plan Letter (APL) 18-023:21-005 (revised): California Children's Services Whole Child Model Program (Supersedes APL 18-011023)
   - Department of Health Care Services All Plan Letter 21-015: Benefit Standardization and MMCE Provisions of CalAIM
   - Medi-Cal Provider Manual (Transplants)

Policy Section	Change
II A.	Language added to more closely align APLs identified above
II B.	Language added to identify and clarify eligible centers for transplant, as well as the inclusion of members in the CCS program

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III A. 2.	Identification of transplant and related services that are covered
III A. 2. d.	Division of responsibility effective 1/1/2022 with the implementation of Medi-Cal Rx
III B. 1 - 5	Further clarification of requirements for transplant centers
III C 1. 4	Identification of procedure for transplants related to a CCS eligible condition
III E.	Transportation requirements for transplant recipients and donors
III F.	Procedure for out of network transplants

2. **Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization** establishes the guidelines for CalOptima and Health Networks to notify members, , providers, and any authorized representative of prior authorization determinations. This policy was reviewed to include the requirements of:
   - Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual – Chapter 42 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals 3 Guidance
   - Medi-Cal Provider Manual – Part 1: Medi-Cal Program and Eligibility, TAR Overview. 11 Revised: 01/15/2021

Policy Section	Change
II	Identification of requirements and types of communications required, including translation requirements
II G, H	Delegation of notices and Medical Director requirement for denials, delays, and modifications
III A. 3.b. ii	Requirements related to denial rationale in Notice of Action (NOA)
III A. 3.f, h	Specific attachments to be included in the NOA, as well as requirements for the Terminate NOA
III A. 4, 5	Requirements for the Integrated Denial Notices (IDN) sent to Medicare beneficiaries when services are denied

Fiscal Impact

The recommended action to modify policies GG.1105 and GG.1507 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget.

Rationale for Recommendation

To ensure CalOptima's continuing commitment to conducting its operations in compliance with all applicable state and federal laws and regulations. CalOptima staff recommends that the Board of Directors approve and adopt the presented CalOptima policies and procedures. The updated policies and procedures will supersede prior versions.

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Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. GG.1105: Coverage of Organ and Tissue Transplants (Redline and Clean)
2. GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization (Redline and Clean)

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Policy:	GG.1105
Title:	**Coverage of Organ and Tissue Transplants**
Department:	Medical Management
Section:	Utilization Management
Interim CEO Approval:	*/s/*
Effective Date:	07/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220303 BOD Review Only

I. PURPOSE

This policy defines Transplant coverage for CalOptima Members under the Medi-Cal program.

II. POLICY

A. CalOptima or a Health Network delegated for Transplant services shall cover all Medically Necessary major organ transplants as outlined in this Policy and the Medi-Cal Provider Manual, including all updates and amendments to the Medi-Cal Provider Manual. The following Transplants are covered benefits under Medi-Cal:

1. Heart;
2. Heart and lung;
3. Lung;
4. Bone marrow;
5. Liver;
6. Small bowel;
7. Kidney;
8. Pancreas;
9. Autologous islet cell;
10. Combined liver and kidney;
11. Combined liver and small bowel;
12. Combined kidney and pancreas; and/or

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13. Cornea, skin, tendon and sclera transplants.

~~A.~~B. A Transplant shall be a Covered Service if a Member meets the patient selection criteria as defined in Section ~~II.B. of this Policy:~~III.A. of this Policy and the Transplant is performed by a Medi-Cal approved Center of Excellence (COE) except as provided in this Policy.

1. ~~A~~ Transplant ~~shall~~Programs that perform cornea, autologous islet cell or kidney Transplants are not required to be a ~~Covered Service if~~Medi-Cal approved COE.

~~1.~~2. Pediatric organ Transplants that qualify as a ~~Member is twenty-one (21) years of age or older, or,~~California Children's Services (CCS) eligible condition are required to be performed only in a CCS-approved Special Care Center as specified in Section III.C. of this Policy.

~~1. A Transplant shall be a Covered Service for Members eligible with the Whole Child Model (WCM) program.~~

III. PROCEDURE

A. Selection Criteria

1. A Transplant shall be a Covered Service upon CalOptima's or a Health Network's determination that the Member is a candidate for a Transplant, is compliant with all requirements, and does not have significant contraindications for the Transplant as follows:

   a. Except for Members enrolled in a Health Maintenance Organization (HMO) that is responsible for all Covered Services for its assigned Members under its contract with CalOptima, CalOptima shall be responsible for the provision and payment of Medically Necessary Covered Services related to the Transplant, including but not limited to evaluation of potential Donors and procurement from living or deceased ~~Donors~~Donors, and care coordination in accordance with this Policy and CalOptima Policies GG.1313: Coordination of Care for Transplant Members, FF.1005a Special Payments – Bone Marrow Transplant and Solid Organ Transplant and 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~~for which CalOptima is Financially Responsible.

2. A Transplant and related services~~,~~, including pre-transplantation assessments and appointments, hospitalization, surgery, discharge planning, readmissions due to complications, post-operative services, and Medically Necessary medications not otherwise covered, shall be Covered Services if:

   a. A provider or practitioner obtains authorization for these services from CalOptima in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508: Authorization and Processing of Referrals and GG.1535: Utilization Review Criteria and Guidelines;

   b. The Transplant is performed in an approved facility~~,~~ as set forth in ~~Section III.A. of~~ this Policy; and

   c. The Member is accepted at the approved facility for the ~~following Transplants:~~Transplant.

~~1. Heart;~~

~~2.~~1. ~~Heart and lung;~~

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~~3.1. Lung;~~

~~4.1. Bone marrow;~~

~~5.1. Liver;~~

~~6.1. Small bowel;~~

~~7.1. Kidney;~~

~~8.1. Pancreas;~~

~~9.1. Combined liver and kidney;~~

~~10.1. Combined liver and small bowel;~~

~~11.1. Combined kidney and pancreas; and/or~~

~~i. Cornea, skin, tendon and sclera transplants.~~

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d. Effective January 1, 2022, pharmacy claims and payment for Transplant-related prescription drugs shall be the responsibility of Medi-Cal Rx. CalOptima shall be responsible for Medically Necessary physician administered drugs and facility-based medications billed on a medical claim related to a Transplant.

3. Renal Transplants

a. A renal Transplant and related services are Covered Services if the Transplant is performed at a DHCS-approved Transplant Center.

b. A renal Transplant and related services are Covered Services for Members with a California Children's Services (CCS)-eligible condition if the Transplant is performed at a DHCS-approved Special Care Renal Dialysis and Transplant Center.

c. CalOptima shall consider the selection criteria for a renal Transplant as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR.), Sections 51003 and 51218.

d. CalOptima or a Health Network delegated for Transplant services is responsible for the provision of all services related to a renal Transplant including, but not limited to, evaluation of potential Donors and nephrectomy from living, or deceased, Donors.

4. Cornea, Skin, Tendon, and Sclera Transplants

a. A Transplant and related services for cornea, skin, tendon, and sclera are Covered Services if the Transplant is performed at a Medi-Cal facility or at a designated Special Care Center for Members with a CCS-eligible condition.

b. CalOptima shall consider the selection criteria for such Transplants as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR), Section 51003.

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~~III. PROCEDURE~~

B. DHCS-approved Transplant Centers ~~and CCS~~

1. Except for kidney transplants, all Medi-Cal covered transplants must be performed at a Medi-Cal-approved COE. A Medi-Cal approved COE Transplant ~~Special Care~~Program is program that operates within a hospital setting, is certified and licensed through the Centers for Medicare & Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with Title 42, Code of Federal Regulations parts 405, 482, 488, 498, and section 1138 of the Social Security Act (Attachment A).

~~2. A DHCS-approved Transplant Center is a facility that is approved by DHCS to provide specific Transplant services for Medi-Cal Members.~~

~~3. A CCS-approved Transplant Center for all Transplants is a Special Care Center that is approved by DHCS, to provide specific Transplant services for CCS WCM eligible Members as determined by CCS in accordance with CalOptima Policy GG.1401: Whole-Child Model – Coordination with County CCS Program.~~

a. Solid Organ Transplant Programs must meet the CMS Conditions of Participation for a specific organ type and must maintain an active membership with the Organ Procurement and Transplantation Network (OPTN) administered by the United Network for Organ Sharing (UNOS).

b. Bone marrow Transplant Programs shall have current accreditation by the Foundation for the Accreditation of Cellular Therapy (FACT).

~~4.~~2. A DHCS-approved Transplant Center for a renal Transplant ~~for a renal Transplant~~ is a facility that:

a. Is certified for, and participates in, the Medicare program;

b. Meets standards established by CMS or DHCS; and

c. Is certified by DHCS, to participate in the Medi-Cal program.

3. CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS-approved Transplant Center, whose certification by DHCS is probationary.

4. If a CMS- or DHCS-approved Transplant Center loses its certification by DHCS or CMS, CalOptima shall transfer any Members who are awaiting Transplants at such facility and shall notify a Member with an active referral to the Transplant Center no later than thirty (30) calendar days prior to the planned inactivation date.

5. Contracted hospitals within which Transplant Programs are located, shall meet DHCS' criteria, be enrolled to participate in the Medi-Cal program, and be evaluated in accordance with CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers.

C. CCS-approved Transplant Special Care Centers

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1. For Transplants made necessary by a CCS-eligible condition, the Transplant is required to be performed only in a CCS-approved Special Care Center (SCC). SCCs are within CCS-approved hospitals that provide comprehensive, coordinated health care to CCS-eligible beneficiaries. Transplants for CCS-eligible beneficiaries must be performed in a SCC that has been approved for the specific organ and age group (Attachment B). Special Care Centers shall meet the following criteria:

   a. Have both a CCS program approved center for the specific organ and appropriate pediatric subspecialists on the hospital staff;

   b. Include participation of the CCS-paneled pediatric subspecialists with the appropriate specialty for the specific organ, for the care of all patients under the age of 18 years; and

   c. Admit all patients under the age of 14 years to a pediatric unit or floor.

~~1.~~2. CalOptima or a Health Network shall identify a DHCS CCS-approved Transplant Special Care Center based upon information, documentation and representation received from DHCS and CCS.

~~5.~~ CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS-~~approved Transplant Center, whose certification by DHCS is probationary.~~

~~2.~~3. ~~CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS~~ and CCS-approved Transplant Special Care Center, whose certification by DHCS CCS is probationary.

~~6. If a CMS- or DHCS-approved Transplant Center loses its certification by DHCS or CMS, CalOptima shall have the right to transfer any Members who are awaiting Transplants at such facility.~~

~~3.~~4. If a DHCS CCS-approved Transplant Special Care Center loses its certification by DHCS CCS, CalOptima shall ~~have the right to~~ transfer any Members who are awaiting Transplants at such facility~~.~~ and shall notify a Member with an active referral to the Transplant Center no later than thirty (30) calendar days prior to the planned inactivation date.

~~B. A DHCS-approved Transplant Center for Bone Marrow, Heart, Lung, Liver or Kidney Transplants is a Special Care Center that:~~

~~1. Provides comprehensive, coordinated health care to CCS clients with specific medical conditions.~~

~~2. Meets standards established by DHCS; and~~

~~3. Is approved by DHCS to participate in the CCS program~~

~~B.~~D. CalOptima shall process and pay claims for Transplants and related services in accordance with CalOptima Policies FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant, and 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.

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E. CalOptima shall authorize appropriate Non-emergency Medical Transportation and Non-Medical Transportation services for Transplant recipients and living Donors in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

F. Out-of-Network Transplants

1. If a Transplant Program cannot perform the major organ transplant surgery and an organ is available, CalOptima may arrange for the surgery to be performed at a different Transplant Program outside its network in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services. CalOptima shall ensure that the Transplant Program meets DHCS' COE requirements based on the following criteria:

a. CMS approval for the appropriate organ; and

i. OPTN membership for solid organ Transplants; or

ii. Accreditation by the FACT for bone marrow Transplants.

b. CCS-approved Special Care Center within a tertiary hospital.

2. CalOptima may authorize a major organ Transplants to be performed outside of California if the reason for the major organ Transplant to be provided out-of-state is advantageous to the Member and the Member agrees to receiving the major organ Transplant out-of-state.

a. CalOptima shall ensure the process for referring, authorizing referrals and coordinating Transplants is not more restrictive than for in-state Transplants and the facility is designated by CMS to perform Transplants for a specific type of organ, is a current beneficiary of the OPTN, and is enrolled as a Medi-Cal provider.

IV. ATTACHMENT(S)

~~Not Applicable~~
A. Medi-Cal approved Centers of Excellence
B. California Children's Services (CCS)-approved Special Care Centers for Transplants

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant
C. 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~~for which CalOptima is Financially Responsible
D. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
E. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program
F. CalOptima Policy GG.1505: Emergency, Non-Emergency, and Non-Medical
G. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
H. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
~~F.~~I. CalOptima Memorandum of Understanding with California Children's Services
~~G.~~J. CalOptima Utilization Management Program
~~H.~~K. Department of Health Care Services All Plan Letter ~~18-023:~~21-005 (revised): California Children's Services Whole Child Model Program (Supersedes APL 18-~~011~~023)

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L. Department of Health Care Services All Plan Letter 21-015: Benefit Standardization and MMCE Provisions of CalAIM
~~I.~~M. Department of Health Care Services Operating Instruction Letter 139-06, Pancreas Transplants
N. Medi-Cal Provider Manual (Transplants)
O. Social Security Act, §1138
P. Title 42, Code of Federal Regulations, Parts 405, 482, 488 and 498
~~J.~~Q. Title 22, California Code of Regulations (CCR), §§51003 and 51218
~~K.~~R. Welfare and Institutions Code, §§14132.69, 14132.70, 14132.71, and 14133.8

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
02/24/2016	Department of Health Care Services (DHCS)
10/21/2021	Department of Health Care Services (DHCS)
11/29/2021	Department of Health Care Services (DHCS)
01/03/2022	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	07/01/1995	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	01/01/2007	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	11/01/2015	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	12/05/2019	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	10/01/2020	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	04/01/2021	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	TBD	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal

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IX. GLOSSARY

Term	Definition
Bone Marrow Transplant	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient (autologous), a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donor (MUD) with human histocompatibility antigens (HL-A) that meet the Department of Health Care Services (DHCS) standards.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible 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.
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, 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~~Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter ~~18~~(APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article ~~3.9~~5.51, beginning with section ~~14127), for HHP Members with eligible physical chronic conditions and substance use disorders,~~14184.100), 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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS-approved Transplant Center	Facilities that are approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplants, a DHCS-approved Transplant Center is a facility that: ~~1.~~ 1. Is certified for, and participates in, the Medicare program~~:~~; and 2. ~~2.~~ Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant.

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Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Emergency Medical Transportation (NEMT)	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Non-Medical Transportation (NMT)	Transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combine liver and small bowel; or 9. Combined kidney and pancreas
Transplant	A non-experimental procedure for human tissue or organ Transplant.
Transplant Program	A unit within a hospital that has received approval from the Centers for Medicare & Medicaid Services (CMS) to perform transplants for a specific type of organ and is a current beneficiary of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS).

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Policy:	GG.1105
Title:	**Coverage of Organ and Tissue Transplants**
Department:	Medical Management
Section:	Utilization Management
Interim CEO Approval:	*/s/*
Effective Date:	07/01/1995
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220303 BOD Review Only

I. PURPOSE

This policy defines Transplant coverage for CalOptima Members under the Medi-Cal program.

II. POLICY

A. CalOptima or a Health Network delegated for Transplant services shall cover all Medically Necessary major organ transplants as outlined in this Policy and the Medi-Cal Provider Manual, including all updates and amendments to the Medi-Cal Provider Manual. The following Transplants are covered benefits under Medi-Cal:

1. Heart;
2. Heart and lung;
3. Lung;
4. Bone marrow;
5. Liver;
6. Small bowel;
7. Kidney;
8. Pancreas;
9. Autologous islet cell;
10. Combined liver and kidney;
11. Combined liver and small bowel;
12. Combined kidney and pancreas; and/or

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13. Cornea, skin, tendon and sclera transplants.

B. A Transplant shall be a Covered Service if a Member meets the patient selection criteria as defined in Section III.A. of this Policy and the Transplant is performed by a Medi-Cal approved Center of Excellence (COE) except as provided in this Policy.

1. Transplant Programs that perform cornea, autologous islet cell or kidney Transplants are not required to be a Medi-Cal approved COE.

2. Pediatric organ Transplants that qualify as a California Children's Services (CCS) eligible condition are required to be performed only in a CCS-approved Special Care Center as specified in Section III.C. of this Policy.

III. PROCEDURE

A. Selection Criteria

1. A Transplant shall be a Covered Service upon CalOptima's or a Health Network's determination that the Member is a candidate for a Transplant, is compliant with all requirements, and does not have significant contraindications for the Transplant as follows:

a. Except for Members enrolled in a Health Maintenance Organization (HMO) that is responsible for all Covered Services for its assigned Members under its contract with CalOptima, CalOptima shall be responsible for the provision and payment of Medically Necessary Covered Services related to the Transplant, including but not limited to evaluation of potential Donors and procurement from living or deceased Donors, and care coordination in accordance with this Policy and CalOptima Policies GG.1313: Coordination of Care for Transplant Members, FF.1005a Special Payments – Bone Marrow Transplant and Solid Organ Transplant and FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

2. A Transplant and related services, including pre-transplantation assessments and appointments, hospitalization, surgery, discharge planning, readmissions due to complications, post-operative services, and Medically Necessary medications not otherwise covered, shall be Covered Services if:

a. A provider or practitioner obtains authorization for these services from CalOptima in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, GG.1508: Authorization and Processing of Referrals and GG.1535: Utilization Review Criteria and Guidelines;

b. The Transplant is performed in an approved facility as set forth in this Policy; and

c. The Member is accepted at the approved facility for the Transplant.

d. Effective January 1, 2022, pharmacy claims and payment for Transplant-related prescription drugs shall be the responsibility of Medi-Cal Rx. CalOptima shall be responsible for Medically Necessary physician administered drugs and facility-based medications billed on a medical claim related to a Transplant.

3. Renal Transplants

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a. A renal Transplant and related services are Covered Services if the Transplant is performed at a DHCS-approved Transplant Center.

b. A renal Transplant and related services are Covered Services for Members with a California Children's Services (CCS)-eligible condition if the Transplant is performed at a DHCS-approved Special Care Renal Dialysis and Transplant Center.

c. CalOptima shall consider the selection criteria for a renal Transplant as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR.), Sections 51003 and 51218.

d. CalOptima or a Health Network delegated for Transplant services is responsible for the provision of all services related to a renal Transplant including, but not limited to, evaluation of potential Donors and nephrectomy from living, or deceased, Donors.

4. Cornea, Skin, Tendon, and Sclera Transplants

a. A Transplant and related services for cornea, skin, tendon, and sclera are Covered Services if the Transplant is performed at a Medi-Cal facility or at a designated Special Care Center for Members with a CCS-eligible condition.

b. CalOptima shall consider the selection criteria for such Transplants as met if CalOptima determines that the Transplant is Medically Necessary, in accordance with Title 22, California Code of Regulations (CCR), Section 51003.

B. DHCS-approved Transplant Centers

1. Except for kidney transplants, all Medi-Cal covered transplants must be performed at a Medi-Cal-approved COE. A Medi-Cal approved COE Transplant Program is program that operates within a hospital setting, is certified and licensed through the Centers for Medicare & Medicaid Services (CMS), and meets Medi-Cal state and federal regulations consistent with Title 42, Code of Federal Regulations parts 405, 482, 488, 498, and section 1138 of the Social Security Act (Attachment A).

a. Solid Organ Transplant Programs must meet the CMS Conditions of Participation for a specific organ type and must maintain an active membership with the Organ Procurement and Transplantation Network (OPTN) administered by the United Network for Organ Sharing (UNOS).

b. Bone marrow Transplant Programs shall have current accreditation by the Foundation for the Accreditation of Cellular Therapy (FACT).

2. A DHCS-approved Transplant Center for a renal Transplant is a facility that:

a. Is certified for, and participates in, the Medicare program;

b. Meets standards established by CMS or DHCS; and

c. Is certified by DHCS, to participate in the Medi-Cal program.

3. CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS-approved Transplant Center, whose certification by DHCS is probationary.

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4. If a CMS- or DHCS-approved Transplant Center loses its certification by DHCS or CMS, CalOptima shall transfer any Members who are awaiting Transplants at such facility and shall notify a Member with an active referral to the Transplant Center no later than thirty (30) calendar days prior to the planned inactivation date.

5. Contracted hospitals within which Transplant Programs are located, shall meet DHCS' criteria, be enrolled to participate in the Medi-Cal program, and be evaluated in accordance with CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers.

C. CCS-approved Transplant Special Care Centers

1. For Transplants made necessary by a CCS-eligible condition, the Transplant is required to be performed only in a CCS-approved Special Care Center (SCC). SCCs are within CCS-approved hospitals that provide comprehensive, coordinated health care to CCS-eligible beneficiaries. Transplants for CCS-eligible beneficiaries must be performed in a SCC that has been approved for the specific organ and age group (Attachment B). Special Care Centers shall meet the following criteria:

   a. Have both a CCS program approved center for the specific organ and appropriate pediatric subspecialists on the hospital staff;

   b. Include participation of the CCS-paneled pediatric subspecialists with the appropriate specialty for the specific organ, for the care of all patients under the age of 18 years; and

   c. Admit all patients under the age of 14 years to a pediatric unit or floor.

2. CalOptima or a Health Network shall identify a DHCS CCS-approved Transplant Special Care Center based upon information, documentation and representation received from DHCS and CCS.

3. CalOptima's Chief Medical Officer (CMO) or Designee shall have the authority to determine CalOptima coverage of a Transplant performed at a DHCS- and CCS-approved Transplant Special Care Center, whose certification by DHCS CCS is probationary.

4. If a DHCS CCS-approved Transplant Special Care Center loses its certification by DHCS CCS, CalOptima shall transfer any Members who are awaiting Transplants at such facility and shall notify a Member with an active referral to the Transplant Center no later than thirty (30) calendar days prior to the planned inactivation date.

D. CalOptima shall process and pay claims for Transplants and related services in accordance with CalOptima Policies FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant, and 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 shall authorize appropriate Non-emergency Medical Transportation and Non-Medical Transportation services for Transplant recipients and living Donors in accordance with CalOptima Policy GG.1505: Transportation: Emergency, Non-Emergency, and Non-Medical.

F. Out-of-Network Transplants

For 20220303 BOD Review Only

1. If a Transplant Program cannot perform the major organ transplant surgery and an organ is available, CalOptima may arrange for the surgery to be performed at a different Transplant Program outside its network in accordance with CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services. CalOptima shall ensure that the Transplant Program meets DHCS' COE requirements based on the following criteria:

    a. CMS approval for the appropriate organ; and

        i. OPTN membership for solid organ Transplants; or

        ii. Accreditation by the FACT for bone marrow Transplants.

    b. CCS-approved Special Care Center within a tertiary hospital.

2. CalOptima may authorize a major organ Transplants to be performed outside of California if the reason for the major organ Transplant to be provided out-of-state is advantageous to the Member and the Member agrees to receiving the major organ Transplant out-of-state.

    a. CalOptima shall ensure the process for referring, authorizing referrals and coordinating Transplants is not more restrictive than for in-state Transplants and the facility is designated by CMS to perform Transplants for a specific type of organ, is a current beneficiary of the OPTN, and is enrolled as a Medi-Cal provider.

IV. ATTACHMENT(S)

A. Medi-Cal approved Centers of Excellence
B. California Children's Services (CCS)-approved Special Care Centers for Transplants

V. REFERENCE(S)

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Policy FF.1005a: Special Payments – Bone Marrow Transplant and Solid Organ Transplant
C. CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible
D. CalOptima Policy GG.1313: Coordination of Care for Transplant Members
E. CalOptima Policy GG.1101: California Children's Services (CCS)/Whole Child Model – Coordination with County CCS Program
F. CalOptima Policy GG.1505: Emergency, Non-Emergency, and Non-Medical
G. CalOptima Policy GG.1539: Authorization for Out-of-Network and Out-of-Area Services
H. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
I. CalOptima Memorandum of Understanding with California Children's Services
J. CalOptima Utilization Management Program
K. Department of Health Care Services All Plan Letter 21-005 (revised): California Children's Services Whole Child Model Program (Supersedes APL 18-023)
L. Department of Health Care Services All Plan Letter 21-015: Benefit Standardization and MMCE Provisions of CalAIM
M. Department of Health Care Services Operating Instruction Letter 139-06, Pancreas Transplants
N. Medi-Cal Provider Manual (Transplants)
O. Social Security Act, §1138
P. Title 42, Code of Federal Regulations, Parts 405, 482, 488 and 498
Q. Title 22, California Code of Regulations (CCR), §§51003 and 51218
R. Welfare and Institutions Code, §§14132.69, 14132.70, 14132.71, and 14133.8

For 20220303 BOD Review Only

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency
02/24/2016	Department of Health Care Services (DHCS)
10/21/2021	Department of Health Care Services (DHCS)
11/29/2021	Department of Health Care Services (DHCS)
01/03/2022	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	07/01/1995	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	01/01/2007	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	11/01/2015	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	10/01/2016	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	08/01/2017	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal OneCare OneCare Connect
Revised	12/05/2019	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	10/01/2020	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	04/01/2021	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal
Revised	TBD	GG.1105	Coverage of Organ and Tissue Transplants	Medi-Cal

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IX. GLOSSARY

Term	Definition
Bone Marrow Transplant	A procedure in which a patient's bone marrow is destroyed by chemotherapy or radiotherapy and replaced with new bone marrow from a Donor. The Donor may be the patient (autologous), a sibling with human histocompatibility antigens (HL-A) identical to the patient's, or a matched unrelated donor (MUD) with human histocompatibility antigens (HL-A) that meet the Department of Health Care Services (DHCS) standards.
California Children's Services (CCS) Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible 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.
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, 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 Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), 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.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
DHCS-approved Transplant Center	Facilities that are approved by the Department of Health Care Services (DHCS) to provide specific Transplant services. For renal transplants, a DHCS-approved Transplant Center is a facility that: 1. Is certified for, and participates in, the Medicare program; and 2. Meets standards established by DHCS and is certified by DHCS to participate in the Medi-Cal program.
Donor	For the purposes of this policy, refers to an individual who undergoes a surgical operation for the purpose of donating a body organ or human tissue or cells for Transplant.

For 2022 0309 BOD Review Only

Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Non-Emergency Medical Transportation (NEMT)	Ambulance, litter van and wheelchair van medical transportation services when the Member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care, per Title 22, CCR, Sections 51231.1 and 51231.2, rendered by licensed Providers.
Non-Medical Transportation (NMT)	Transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons not registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.
Solid Organ Transplant	A Transplant for: 1. Heart; 2. Heart and lung; 3. Lung; 4. Liver; 5. Small bowel; 6. Kidney; 7. Combined liver and kidney; 8. Combine liver and small bowel; or 9. Combined kidney and pancreas
Transplant	A non-experimental procedure for human tissue or organ Transplant.
Transplant Program	A unit within a hospital that has received approval from the Centers for Medicare & Medicaid Services (CMS) to perform transplants for a specific type of organ and is a current beneficiary of the Organ Procurement and Transplantation Network (OPTN), which is administered by the United Network for Organ Sharing (UNOS).

For 20220302 BOD Review Only

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Medi-Cal Approved Centers of Excellence (COE) for Transplantation

Transplant Type	COE	Location	Adult	Child (0-21)
Bone Marrow	Cedars-Sinai Medical Center	Los Angeles	Y	
Bone Marrow	Children's Hospital of Los Angeles	Los Angeles		Y
Bone Marrow	Children's Hospital of Orange County	Orange		Y
Bone Marrow	Children's Hospital, Oakland	Oakland		Y
Bone Marrow	City of Hope National Medical Center	Duarte	Y	Y
Bone Marrow	Loma Linda University Medical Center	Loma Linda		Y
Bone Marrow	Rady Children's Hospital	San Diego		Y
Bone Marrow	Scripps Blood and Marrow Transplant Program	La Jolla	Y	
Bone Marrow	Stanford Medical Center	Palo Alto	Y	
Bone Marrow	Stanford-Lucile Packards Children's Hospital	Palo Alto		Y
Bone Marrow	Sutter Medical Center	Sacramento	Y	
Bone Marrow	University of California, Davis	Sacramento	Y	
Bone Marrow	University of California, Los Angeles	Los Angeles	Y	Y
Bone Marrow	University of California, San Diego	San Diego	Y	
Bone Marrow	University of California, San Francisco	San Francisco	Y	Y
Bone Marrow	University of Southern California, Norris Cancer Center	Los Angeles	Y	
Heart	California Pacific Medical Center	San Francisco	Y	
Heart	Cedars-Sinai Medical Center	Los Angeles	Y	
Heart	Children's Hospital of Los Angeles	Los Angeles		Y
Heart	Keck Hospital of University of Southern California	Los Angeles	Y	
Heart	Loma Linda University Medical Center	San Bernadino	Y	Y
Heart	Rady Children's Hospital	San Diego		Y
Heart	Sharp Memorial Hospital	San Diego	Y	
Heart	Stanford Medical Center	Palo Alto	Y	
Heart	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Heart	Sutter Memorial Hospital	Sacramento	Y	
Heart	University of California, Los Angeles	Los Angeles	Y	Y
Heart	University of California, San Diego	San Diego	Y	
Heart	University of California, San Francisco	San Francisco	Y	

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Transplant Type	COE	Location	Adult	Child (0-21)
Intestinal	Children's Hospital of Los Angeles	Los Angeles		Y
Intestinal	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Intestinal	University of California, Los Angeles	Los Angeles	Y	
Kidney-Pancreas	California Pacific Medical Center	San Francisco	Y	
Kidney-Pancreas	Loma Linda University Medical Center	Loma Linda	y	
Kidney-Pancreas	University of California, Irvine	Irvine	Y	
Kidney-Pancreas	University of California, San Francisco	San Francisco	Y	
Liver	California Pacific Medical Center	San Francisco	Y	
Liver	Cedars-Sinai Medical Center	Los Angeles	Y	
Liver	Children's Hospital of Los Angeles	Los Angeles		Y
Liver	Keck Hospital, University of Southern California	Los Angeles	Y	
Liver	Loma Linda University Medical Center	San Bernadino	Y	
Liver	Scripps Green Hospital	San Diego	Y	
Liver	Stanford Medical Center	Palo Alto	Y	
Liver	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Liver	University of California, Los Angeles	Los Angeles	Y	Y
Liver	University of California, San Diego	San Diego	Y	
Liver	University of California, San Francisco	San Francisco	Y	Y
Lung	Cedars-Sinai Medical Center	Los Angeles	Y	
Lung	Keck Hospital, University of Southern California	Los Angeles	Y	
Lung	Stanford Medical Center	Palo Alto	Y	
Lung	Stanford-Lucile Packard Children's Hospital	Palo Alto		Y
Lung	University of California, San Diego	San Diego	Y	
Lung	Universty of California, Los Angeles	Los Angeles	Y	
Lung	University of California, San Francisco	San Francisco	Y	

Table 1: Medi-Cal Transplant Center of Excellence by Transplant Type and Adult/Child

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Medi-Cal Approved Centers of Excellence (COE) for Transplantation

Centers are listed by type of organ transplant. Transplant program Surgical (S) or Medical (M) Director, and program contact names follow the facility name. Only Medical Directors are listed for Bone Marrow Transplant Centers.
Adult applies to facilities approved for clients ≥ 21 years old (y.o.) and Pediatric applies to facilities approved for clients < 21 y.o. Clients referred to Integrated Systems of Care Division (ISCD)/California Children's Services (CCS) Program staff by Medi-Cal approved COEs for pediatric transplant are case managed by ISCD Branch/CCS Program staff.

Bone Marrow Transplants (BMT)

BMT contacts are administrative and quality control. Medical Directors are from the FACT roster for California

Adult-Only BMT Transplants

Cedars-Sinai Medical Center (Los Angeles)
Contact: Nancy Eng
Email: Nancy.Eng@cshs.org
Telephone: 310-423-2107
Medical Director: Ronald Parquette, MD

Scripps (La Jolla)
Contact: Michelle Meyer
Email: Meyer.Michelle@scrippshealth.org
Telephone: 858-554-4340
Head, Division of Oncology: James Mason, MD

Stanford Medical Center (Palo Alto)
Contact: Tawny Wong Lough, Division Manager
Email: tawnyw@stanford.edu
Telephone: 650-725-1715
Medical Director: Robert Negrin, MD

Sutter Medical Center (Sacramento)
Contact: Yuliya Smirnov, Clinical Program Quality Manager
Email: SmirnoY@sutterhealth.org
Telephone: 916-454-6512
Medical Director: Michael P Carroll, MD

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Adult-Only BMT Transplants, continued

University of California, Davis (Sacramento)
Contact: Carol Richman, MD
Email: cmrichman@UCDAVIS.EDU
Telephone: 916-734-3772
Medical Director: Carol Richman, MD

University of California, San Diego (La Jolla)
Contact: Patti Kicak
Email: pkicak@ucsd.edu
Telephone: 858-822-6393
Medical Director: Edward (Ted) Ball, MD

University of Southern California, Norris Cancer Center (Los Angeles)
Contact: Sosy Fincher, RN, MSN, AOCN, CNS; Director of Operations
Email: Sosy. Fincher@med.usc.edu
Telephone: 323-865-0904
Medical Director: Preet M. Chaudary, MD

Pediatric-Only BMT

Children's' Hospital of Los Angeles (Los Angeles)
Contact: Rafael Bravo Lopez , Quality Improvement Coordinator II
Email: Rblopez@chla.usc.edu
Telephone: 323-361-8570
Medical Director: Neena Kapoor, MD

Children's Hospital of Orange County (Orange)
Contact: Barbara Knight, Quality and Accreditation Coordinator
Email: bknight@choc.org
Telephone: 714-509-9315
Medical Director: Rishikesh Chavan, MD

Children's Hospital, Oakland (Oakland)
Contact: Nancy Noonan
Email: nnoonan@mail.cho.org
Telephone: 510-428-3885 x 2835
Program Director/Medical Director: Mark Walters, MD
Program Director, per FACT: Shannon Kelly, MD

For 20220303 BOD Review Only

Pediatric-Only BMT, continued

Loma Linda University Medical Center (Loma Linda)
Contact: Mojtaba Akhtari, MD, FACP [Adult COE application received– issues]
Email: Not available
Telephone: 951-290-6379
Medical Director, Adult: Wesley Tait Stevens, MD
Medical Director, Pediatric: Albert Kheradpour, MD

Rady Children's Hospital (San Diego)
Contact: Liz Sheldon, Rn, CPNP, PCNS, CPHON, Nurse Practitioner/BMT QA
Email: ESheldon@rchsd.org
Telephone: 858-576-1700 x 3676
Medical Director: Edward Ball, MD

Stanford – Lucile Packard Children's Hospital (Palo Alto)
Contact: Angela Koptksy
Email: akopetsky@stanfordchildrens.org
Telephone: 650-723-0310
Medical Director: Robert Negrin, MD [FACT]

Adult and Pediatric BMT

City of Hope National Medical Center (Duarte)
Contact: Joel Ricafort
Email: jricafort@coh.org
Telephone: 626-218-8762
Medical Director: Stephen J. Forman, MD

University of California, Los Angeles (Los Angeles)
Contact: Heather Steinmetz, MPH, QA Manager – HMSCT Program
Email: hsteinmetz@mednet.ucla.edu
Telephone: 310-267-8274
Medical Director: Gary Schiller, MD, FACP

University of California, San Francisco (San Francisco)
Contact: Erwin Carino, Quality Manager
Email: Erwin.Carino@ucsf.edu
Telephone: 415-353-4131
Medical Director, Adult: Thomas Martin, MD
Program Director, Pediatrics: Sandhya Kharbanda, MD

For 20220303 BOD Review Only

Heart Transplant COEs

Adults-only Heart Transplant

California Pacific Center (San Francisco)
Contact: Christine Moyle (Administrative Director)
Email: moylec@sutterhealth.org
Telephone: 415-600-1128
Program Director: Mic Brett Sheridan, MD
Primary Physician: Michael Pham, MD
Primary Surgeon: Brett Sheridan, MD

Cedars Sinai Medical Center (Los Angeles)
Contact: Robert Luga
Email: bert.iuga@cshs.org
Telephone: 310-423-6707
Program Director: Jon Kobashigawa, MD
Primary Physician: Jon Kobashigawa, MD
Primary Surgeon: Faradad Esmailian, MD

Keck Hospital of University of Southern California
Contact: Jenna Graciano
Email: Jenna.Graciano@med.usc.edu
Telephone: 323-442-0264
Program Director: Mark Cunningham, MD
Primary Physician: Eugene C. Depasquale, MD
Primary Surgeon: Mark Cunningham, MD

Sharp Memorial Hospital (San Diego)
Contact: Cindy Walsh
Email: Cynthia.Walsh@sharp.com
Telephone: 858-939-5009
Program Director: Robert Adamson, MD
Primary Physician: Brian Jaski, MD
Primary Surgeon: Robert Adamson, MD

Stanford Memorial Hospital (Palo Alto)
Contact: Christine Hartley, Administrative Director
Email: chartley@stanfordhealthcare.org
Telephone: 650-498-6185
Program Director: Pillip Oyer, MD
Primary Physician: Jeffery Teuteburg, MD
Primary Surgeon: Joseph Woo, MD

For 20220303 BOD Review Only

Adults-Only Heart Transplant, continued

Sutter Memorial Hospital (Sacramento)
Contact: Dee Sanchez
Email: dsanchez@saccardio.com
Telephone: No phone number listed
Program Director: Robert Kincade, MD
Primary Physician: John Chin, MD
Primary Surgeon: Robert Kincade, MD

University of California, San Diego (San Diego)
Contact: Tim Stevens, Interim Transplant Director
Email: tjstevens@ucsd.edu
Telephone: 858-657-7729
Program Director: Eric Adler, MD
Primary Physician: Eric Adler, MD
Primary Surgeon: Gert Pretorius, MD

University of California, San Francisco (San Francisco)
Contact: Anna Mello, Transplant Quality Manger
Email: anna.mello@ucsf.edu
Telephone: 415-203-7720
Program Director: Teresa De Marco, MD
Primary Physician: Teresa De Marco, MD
Primary Surgeon: Georg Wieselthaler, MD

Pediatrics-Only Heart Transplant

Children's Hospital of Los Angeles (Los Angeles)
Contact: Stephanie Johnson, Administrator, Transplant Services
Email: sjohnson@chla.usc.edu
Telephone: 323-361-6380
Program Director: Not listed
Primary Physician: Jon David Menteer, MD
Primary Surgeon: Cynthia Herrington, MD

Rady's Children's Hospital (San Diego)
Contact: Emily A Fletcher
Email: EFletcher1@rchsd.org
Telephone: 858-966-5855 x 7995
Program Director: Rakesh Singh, MD
Primary Physician: Gabrielle Vaughn, MD
Primary Surgeon: John Nigro, MD

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Pediatrics-Only Heart Transplant, continued

Stanford – Lucille Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Program Director: Seth Adam Hollander, MD
Primary Physician: David Rosenthal, MD
Primary Surgeon: Teimour A Nasirov, MD

Adults and Pediatrics Heart Transplants

Loma Linda University Medical Center (San Bernardino)
Contact: Melissa Robinson, Quality & Safety Manager
Email: mnrobinson@llu.edu
Telephone: 909-558-3655 x 36746
Medical Director Liset Stoletniy, MD
Primary Physician: Liset Stoletniy, MD
Primary Surgeon: Joshua Chung, MD

University of California, Los Angeles (Los Angeles)
Contact: Nicholas J. Feduska, Jr., Assistant Director, Transplant Services
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director, Adult: Ali Nsair, MD
Primary Physician: Ali Nsair, MD
Primary Surgeon: Abbas, Ardelhali, MD

Intestinal Transplants COEs

Adults-only Intestinal Transplants

University of California, Los Angeles (Los Angeles)
Contact: Nicholas J. Feduska, Jr., Assistant Director, Transplant Services
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director: Robert Venick, MD
Primary Physician: Robert Vinick, MD
Primary Surgeon: Doulas Farmer, MD

For 20220303 BOD Review Only

Pediatrics-Only Intestinal Transplants

Children's Hospital of Los Angeles (Los Angeles)
Contact: Stephanie Johnson, Administrator, Transplant Services
Email: sjohnson@chla.usc.edu
Telephone: 323-361-6380
Program Director: Yuri, Genyk, MD
Primary Physician: Rohit Kohli, MD
Primary Surgeon: Kambiz Etesami, MD

Stanford – Lucille Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Program Director: Carlos Esquivel, MD
Primary Physician: William Berquist, MD
Primary Surgeon: Clark Bonham, MD

Kidney-Pancreas Transplant COEs

Adults-Only

Californian Pacific Medical Center (San Francisco)
Contact: Christine Moyle, Administrative Director
Email: moylec@sutterhealth.org
Telephone: 415-600-1128
Program Director, Kidney: William I. Bry
Primary Physician, Kidney: Steven Katznelson
Primary Surgeon, Kidney: William I. Bry
Program Director, Pancreas: Parul S. Patel, MD/ Harish Mahanty, MD
Primary Physician, Pancreas: Parul S. Patel, MD
Primary Surgeon, Pancreas: Harish Mahanty, MD

Loma Linda University Medical Center (San Bernardino)
Contact: Melissa Robinson, Quality & Safety Manager
Email: mnrobinson@llu.edu
Telephone: 909-558-3655 x 36746
Program Director: Rafael Villicana, MD/ Charles F Bratton, MD
Primary Physician, Kidney: Rafael Villicana, MD
Primary Surgeon, Kidney: Charles F Bratton, MD
Primary Physician, Pancreas: Rafael Villicana, MD
Primary Surgeon, Pancreas: Charles F Bratton, MD

For 2022003 BOD Review Only

Kidney-Pancreas Transplant, Adult-only continued

University of California Irvine (Irvine)
Contact: Anthony Palanca
Email: apalanca@hs.uci.edu
Telephone: 714-456-7472
Medical Director, Kidney: Uttam G Reddy, MD
Tranplant Program Director, Kidney: Hirohito Ichii, MD
Primary Physician, Kidney: Uttam G Reddy, MD Hirohito Ichii, MD
Primary Surgeon, Kidney: Hirohito Ichii, MD
Tranplant Program Director, Pancreas: Hirohito Ichii, MD
Primary Physician, Pancreas: Uttam G Reddy, MD
Primary Surgeon, Pancreas: Hirohito Ichii, MD

University of California San Francisco Medical Center (San Francisco)
Contact: Anna Mello, Transplant Quality Manager
Email: anna.mello@ucsf.edu
Telephone: 415-203-7720
Medical Director, Kidney: Deborah Adey, MD
Tranplant Program Director, Kidney: John P Roberts, Deborah Adey, MD
Primary Physician, Kidney: Deborah Adey, MD
Primary Surgeon, Kidnely: Chris E. Freise, MD
Tranplant Program Director, Pancreas: Peter G. Stock, MD/Flavio Vicenti, MD
Primary Physician, Pancreas: Minnie Sarwal, MD
Primary Surgeon, Pancreas: Peter G. Stock, MD

Liver Transplant COEs

Adults-Only Liver Transplants

California Pacific Medical Center (San Francisco)
Contact: Christine Moyle, Administrative Director
Email: moylec@sutterhealth.org
Telephone: 415-600-1128
Programl Director: Raphael B. Merriman, MD
Primary Physician: Raphael Merriman, MD
Primary Surgeon: Robert Osario, MD

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Liver Transplants, Adult-Only, conitnued

Cedars-Sinai Medical Center (Los Angeles)
Contact: Robert Luga
Email: robert.iuga@cshs.org
Telephone: 310-423-6707
Programl Director: Walid Ayoub, MD
Primary Physician: Alexander, Kuo, MD
Primary Surgeon: Nocholas Nissen, MD

Keck Hospital of University of Southern California (Los Angeles)
Contact: Jenna Graciano
Email: Jenna.Graciano@med.usc.edu
Telephone: 323-442-0264
Program Director: Yuri Genyk, MD
Primary Physician: Jeffrey Kahn, MD
Primary Surgeon: Yuri Genyk, MD

Loma Linda University Medical Center (San Bernardino)
Contact: Melissa Robinson, Quality & Safety Manager
Email: mnrobinson@llu.edu
Telephone: 909-558-3655 x 36746
Program Director: Michael L. Volk, MD
Primary Physician: Michael L. Volk, MD
Primary Surgeon: Michael De Vera, MD

Scripps Green Hospital (San Diego)
Contact: Michelle Meyer
Email: meyer.michelle@scrippshealth.org
Telephone: 858-554-4340
Medical Director: Catherine Frenette, MD
Primary Physician: Catherine Freneete, MD
Primary Surgeon: Christopher Marsh, MD
Adults-Only Liver Transplants – continued

Stanford Medical Center (Palo Alto):
Contact: Christine Hartley, Administrative Director
Email: chartley@stanfordhealthcare.org
Telephone: 650-498-6185
Program Director: Aijaz Ahmed, MD
Primary Physician: Aijaz Ahmed, MD
Primary Surgeon: Carlos Esquival, MD

For 20220503 BOD Review Only

Liver Transplants, Adult-Only, conitnued

University of California, San Diego (San Diego)
Contact: Tim Stevens, Interim Transplant Director
Email: tjstevens@ucsd.edu
Telephone: 858-657-7729
Program Director: Kristin Mekel, MD
Primary Physician: Rohit Loomba, MD
Primary Surgeon: Gabriel Schnickel, MD

Pediatrics-Only Liver Transplants

Children's Hospital of Los Angeles (Los Angeles)
Contact: Rosa Holguin
Email: rholguin@chla.usc.edu
Telephone: 323-361-8746
Program Director: Yuri Genyck, MD
Primary Physician: Beth Carter, MD
Primary Surgeon: Yuri Genyck, MD

Stanford-Lucile Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Medical Director: William Berquist, MD
Primary Physician: W illiam Berquist, MD
Primary Surgeon: Carlos Equivel, MD

Adults and Pediatrics Liver Transplants

University of California, Los Angeles (Los Angeles)
Contact: Nicholas. J. Feduska, Assistant Director
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director: Ronald Busitil, MD
Primary Physician: Sammy Saab, MD
Primary Surgeon: Ronald Busitil, MD

For 20220303 BOD Review Only

Adults and Pediatrics Liver Transplants, continued

University of California, San Francisco (San Francisco)
Contact: Anna Mello
Email: anna.mello@ucsf.edu
Telephone: 415-203-7720
Program Director: John Roberts, MD
Primary Physician: Francis Yao, MD
Primary Surgeon: John Roberts, MD

Lung Transplant COEs

Adults-Only Lung Transplants

Cedars Sinai Medical Center (Los Angeles)
Contact: Robert Luga
Email: robert.iuga@cshs.org
Telephone: 310-423-6707
Program Director: Danny Ramzy, MD
Primary Physician: Geoge Chaux, MD
Primary Surgeon: Danny Ramzy, MD

Keck Hospital of University of Southern California (Los Angeles)
Contact: Jenny Graciano
Email: Jenna.Graciano@med.usc.edu
Telephone: (323) 442-0264
Program Director: Sivagini Ganesh, MD
Primary Physician: Sivagini Ganesh, MD
Primary Surgeon: Michael McFadden, MD

Stanford Medical Center (Palo Alto):
Contact: Christine Hartley
Email: chartley@stanfordhealthcare.org
Telephone: 650-498-6185
Program Director: Gundeep Dhillon, MD
Primary Physician: Gundeep Dhillon, MD
Primary Surgeon: Joeseph Woo, MD

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Adults-Only Lung Transplants, continued

University of California, Los Angeles (Los Angeles)
Contact: Nicholas J. Feduska, Jr., MSHA; Assistant Director, Transplant Services
Email: nfeduska@mednet.ucla.edu
Telephone: 310-267-9047
Program Director: David M Sayah, MD; Abbas Ardehali, MD
Primary Physician: David M Sayah, MD
Primary Surgeon: Abbas Ardehali, MD

University of California, San Diego (San Diego)
Contact: Tim Stevens, Interim Transplant Director
Email: tjstevens@ucsd.edu
Telephone: 858-657-7729
Program Director: Eugene Golts, MD
Primary Physician: Gordon Yung, MD
Primary Surgeon: Eugene Golts, MD

University of California, San Francisco (San Francisco)
Contact: Anna Mello
Email: anna.mello@ucsf.edu
Telephone: (415) 203-7720
Program Director: Steve Hayes, MD
Primary Physician: Steve Hayes, MD
Primary Surgeon: Jasleen Kukreja, MD

Pediatrics-Only Lung Transplants

Stanford-Lucile Packard Children's Hospital (Palo Alto)
Contact: Joshua E. Gossett
Email: jgossett@stanfordchildrens.org
Telephone: 650-363-0684
Program Director: Carol Conrad, MD
Primary Physician: Carol Conrad, MD
Primary Surgeon: John MacArthur, MD

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California Children's Services (CCS)-approved Special Care Centers for Transplants

Bone Marrow Transplant Centers

Facility Name	City	Center Number
Children's Hospital Los Angeles	Los Angeles	7.19.02
CHOC Children's Hospital Main Campus - Orange	Orange	7.19.03
City of Hope	Duarte	7.19.05 & 7.19.12
Loma Linda University Children's Hospital	Loma Linda	7.19.15
Lucile Packard Children's Hospital Stanford	Palo Alto	7.19.06
Rady Children's Hospital San Diego	San Diego	7.19.04
Stanford Hospital and Clinics	Palo Alto	7.19.11
UCSF Benioff Children's Hospital Oakland	Oakland	7.19.14
UCSF Benioff Children's Hospital San Francisco	San Francisco	7.19.08 & 7.19.9
UCLA Mattel Children's Hospital at Ronald Reagan	Los Angeles	7.19.07 & 7.19.10

Heart and Lung Transplant Centers

Facility Name	City	Center Number
Cedars-Sinai Medical Center	Los Angeles	7.31.08
Keck Hospital of USC	Los Angeles	7.31.6
Lucile Packard Children's Hospital Stanford	Palo Alto	7.31.02
Stanford Hospital & Clinic	Palo Alto	7.31.5
UC San Diego Medical Center	San Diego	7.31.03

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Heart Transplant

Facility Name	City	Center Number
Cedars-Sinai Medical Center	Los Angeles	7.27.08
Children's Hospital Los Angeles	Los Angeles	7.27.6
Loma Linda University Children's Hospital	Loma Linda	7.27.02
Lucile Packard Children's Hospital Stanford	Palo Alto	7.27.03
Rady Children's Hospital San Diego	San Diego	7.27.09
Stanford Hospital & Clinics	Palo Alto	7.27.7
UCLA Mattel Children's Hospital at Ronald Reagan	Los Angeles	7.27.04
UC San Diego Medical Center	San Diego	7.27.05

Liver Transplant Centers

Facility Name	City	Center Number
Children's Hospital Los Angeles	Los Angeles	7.28.6
Lucile Packard Children's Hospital Stanford	Palo Alto	7.28.05
Stanford Hospital & Clinics	Los Angeles	7.28.7
UC San Diego Medical Center	San Diego	7.28.09
UCLA Mattel Children's Hospital at Ronald Reagan	Los Angeles	7.28.03
UCSF Benioff Children's Hospital San Francisco	San Francisco	7.28.04

https://www.dhcs.ca.gov/services/ccs/scc/Pages/SCCType.aspx (December 2021)

For 20220303 BOD Review Only

Policy:	GG.1507
Title:	**Notification Requirements for Covered Services Requiring Prior Authorization**
Department:	Medical Management
Section:	Utilization Management
Interim CEO Approval:	*/s/*
Effective Date:	02/01/1997
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy establishes guidelines by which CalOptima and its Health Networks shall notify a Member, Member's Authorized Representative, Prescribing Practitioner, and Primary Care Practitioner (PCP), when a request for Prior Authorization of a Covered Service is processed.

II. POLICY

A. CalOptima and its Health Networks shall process and authorize requests for Prior Authorization in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

B. CalOptima or a Health Network shall notify a Member, the Member's Authorized Representative, Prescribing Practitioner, and PCP, as appropriate, if:

1. CalOptima or the Health Network denies, modifies, or delays a request for Prior Authorization for a Covered Service requiring Prior Authorization; or

2. CalOptima or the Health Network terminates a previously approved Covered Service.

~~C. CalOptima or a Health Network shall communicate to the Prescribing Practitioner or PCP, a decision to approve, modify, or deny an authorization prior to, or concurrent with the provision of a Covered Service within twenty-four (24) hours of the decision.~~

~~D.~~C. CalOptima or a Health Network shall notify a Member, the Member's Authorized Representative, Prescribing Practitioner, and PCP, as appropriate, with a written Notice of Action (NOA), applicable for Medi-Cal Members; or Integrated Denial Notice (IDN), applicable to OneCare and OneCare Connect Members.

~~E.~~D. NOAs and IDNs shall comply with contractual, State, and Federal requirements, as found in section 51014.1 of Title 22 of the California Code of Regulations, CalOptima's Contract for Health Care Services with its Health Networks, Department of Health Care Services (DHCS) All Plan Letter ~~17-006~~21-011: Grievance and Appeal Requirements ~~and Revised~~, Notice ~~Templates~~ and "Your Rights" ~~Attachments~~Templates, and in the Centers for Medicare & Medicaid Services (CMS)

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Medicare Managed Care Manual – ~~Chapters~~Chapter 4 and ~~13.~~Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

E. CalOptima or a Health Network shall send a NOA or IDN in a timely manner, in accordance with the timelines set forth in Attachments A and B to this Policy, and in compliance with the language requirements of CalOptima Policies CMC.4002: Cultural and Linguistic Services, DD.2002: Cultural and Linguistic Services, and MA.4002: Cultural and Linguistic Services.

1. In providing NOAs and IDNs, CalOptima shall abide by the timing requirements for Medi-Cal service requests contained in Attachment A, and the requirements for Medicare (OneCare and OneCare Connect) service requests contained in Attachment B.

2. As provided in Attachments A and B, the timing in which NOAs and IDNs must be sent to the Member and providers shall be determined by the nature of the request (*e.g.*, expedited, routine) based on the Member's condition and may be affected by whether the provider submits all necessary information with the request.

F. CalOptima shall not be required to send a NOA or IDN if CalOptima approves a drug identical in chemical composition, dosage, and bioequivalence of a requested drug (*i.e.*, when a generic drug is substituted for the brand name drug).

G. A Health Network may delegate the notification requirements set forth in this Policy to a subcontracting medical group. In accordance with delegation oversight requirements, Health Networks shall be responsible for complying and ensuring subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and CalOptima policies and procedures related to notification requirements for Covered Services requiring Prior Authorization.

H. Pursuant to requirements established by DHCS, CMS, and the National Committee on Quality Assurance (NCQA), and as reflected in the DHCS NOA and CMS IDN, a qualified CalOptima Medical Director shall review all medical and pharmacy denials, delays, and modifications for Medically Necessity, or benefit coverage in Prior Authorizations, concurrent reviews, and terminations.

III. PROCEDURE

A. CalOptima and a Health Network shall utilize the template ~~NOAs~~NOA provided by DHCS~~,~~ or CMS, or equivalent language in the NOA or IDN.

1. The NOA and IDN shall include information on accessing interpretive services in Threshold Languages and information regarding accessing Teletype/~~Tele Typewriter~~Teletypewriter (TTY) services.

2. The NOA and IDN shall inform a Member of the Member's right to file for an Appeal for services covered by Medi-Cal, or an Independent Review for services covered by Medicare, upon receiving a notification of denial, delay, modification, reduction, suspension, or termination of Covered Services.

3. For Medi-Cal Covered Services, the NOA shall:

a. Contain a statement of the action CalOptima is taking on the request;

b. Describe the specific reason(s) for the decision in easy to understand language, and provide a reference and explanation of the CalOptima Prior Authorization guidelines or specific

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regulations on which the decision was based;

i. For decisions not based on Medical Necessity, the NOA shall provide a clear and concise explanation of the reasons for the decision.

ii. Decisions to deny services cannot be solely based on requested codes being listed as non-benefits (*i.e.*, in the Medi-Cal Treatment and Authorization (TAR) and Non-Benefit list of codes), and other reasons for the denial must be included in the NOA (*i.e.*, services were determined to be not Medically Necessary and/or did not meet other criteria considered).

c. Define how the Member, Prescribing Practitioner, or PCP can obtain a copy, free of charge, of the actual benefit provision, guideline, protocol, or other criteria on which the denial decision was based;

d. Describe the clinical reasons for the decision and explain how the Member's condition does not meet criteria or guidelines;

e. Inform the Prescribing Practitioner~~,~~ or PCP~~,~~ of the availability of an appropriate Practitioner to discuss the decision and provide contact instructions, including the name and direct telephone number of the healthcare professional responsible for the denial, delay, or modification to allow the Prescribing Practitioner or PCP to easily contact the healthcare professional responsible for the denial, delay, or modification;

f. Include a "Your Rights" attachment that contains general information regarding the Member and Prescriber Practitioner's or PCP's standard and expedited Appeal rights, an explanation of the Appeal process, and instructions on how to submit an Appeal, an explanation and instructions for the State Hearing process, and the right and how to request continuation of Covered Services, along with the nondiscrimination notice and language assistance taglines; and

g. Explain that the Member, Prescribing Practitioner or PCP can provide written comments, documents, or other information to Appeal the denial.

h. If CalOptima or a Health Network terminates an authorization for an ongoing service, CalOptima or a Health Network shall send ~~a~~the NOA ~~or~~at least ten (10) calendar days prior to the date of the termination.

4. For Medicare covered services, the IDN shall:

a. Include a specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (*e.g.*, Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;

b. Provide information regarding a Member's right to Appeal and the right to appoint a representative to file an Appeal on the Member's behalf;

c. For service denials, include a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;

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d. Explain that the Member has a right to submit additional evidence in ~~a timely manner,~~writing or in ~~accordance~~person; and

e. Include an explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

~~4.~~5. CalOptima or a Health Network shall communicate to the Prescribing Practitioner or PCP, a decision to approve, modify, or deny an authorization prior to, or concurrent with the ~~timelines set forth in the Utilization Management Program Description: Timeframes for Decisions and Notifications.~~provision of a Covered Service within twenty-four (24) hours of the decision.

B. Continuation of Benefits Pending an Appeal for Medi-Cal and OneCare Connect Covered Services

~~F.~~ If CalOptima or a Health Network terminates an authorization for an ongoing service, the Member has a right to request continuation of benefits for Medi-Cal and OneCare Connect Covered Services by filing an Appeal within ten (10) calendar days after the date of the mailing of the NOA or IDN, as applicable, ~~in accordance with CalOptima Policy GG.1510: Appeal Process for Decisions Regarding Care and Services.~~

~~G.~~A. ~~CalOptima shall not be required to send a NOA or IDN if CalOptima approves a drug identical in chemical composition, dosage, and bioequivalence of a requested drug (*i.e.*, when a generic drug is substituted for the brand name drug).~~

~~H.~~A. ~~A Health Network may delegate the notification requirements set forth in this policy to a subcontracting group. In accordance with delegation oversight requirements, Health Networks shall be responsible for complying and ensuring subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and CalOptima policies and procedures related to notification requirements for Covered Services requiring Prior Authorization.~~

~~I. Pursuant to requirements established by DHCS, CMS, and the National Committee on Quality Assurance (NCQA), and as reflected in the DHCS NOA and CMS IDN, a qualified CalOptima Medical Director shall review all Prior Authorizations, concurrent reviews, terminations, and pharmacy denials, delays, and modifications for Medical Necessity, or benefit coverage.~~

~~III.~~I. ~~PROCEDURE~~

~~B. Continuation of Benefits Pending an Appeal for Medi-Cal and OneCare Connect Covered Services~~

1. ~~To receive continuing service, a Member shall request an Appeal within ten (10) calendar days after the date of the mailing of the NOA or IDN,~~ or the last date on which services were authorized under the immediately preceding authorization, whichever is later, in accordance with CalOptima Policy GG.1510: Appeal Process.

2. Upon notification that the Member timely requested an Appeal, CalOptima or a Health Network shall authorize continuing services from the date that the previous authorization expired.

3. The authorization shall not be at a level of service greater in amount, or frequency, than approved by the immediately preceding authorization.

4. The authorization period shall be determined according to the following:

   a. Acute Care Continuing Services: The authorization shall be valid until the date an Appeal or State Hearing decision is rendered, the date on which an Appeal is withdrawn or closed,

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the date the treating Practitioner documents that the Member is ready for a lower level of care, or the date of discharge, whichever is earliest.

b. Non-Acute Continuing Services: The authorization shall be valid up to and including the date the Continuing Services were requested by the treating Practitioner, the date an Appeal or State Hearing decision is rendered, or the date on which the hearing Appeal is withdrawn or closed, whichever is earliest.

5. If the Member requests a continuation of services more than ten (10) calendar days after the date of the mailing or hand delivery of the NOA or IDN, or after the last date on which services were authorized under the immediately preceding authorization, whichever is later, CalOptima or a Health Network shall send the Member a Notice of Appeal Resolution (NAR) or IDN stating that the ~~for the~~ request for continued services is denied.

C. Aid Paid Pending a State Hearing for Medi-Cal and OneCare Connect Covered Services

1. To receive continuing service, a Member shall request a State Hearing within ten (10) calendar days after the date of the mailing of the NAR or Appeal resolution IDN, or the last date on which services were authorized under the immediately preceding authorization, ~~which~~whichever is later.

2. Upon timely filing a State Hearing requesting Aid Paid Pending, a Member may be eligible for continuation of benefits in accordance with Section III.~~A~~B. of this Policy.

D. File copies of all notification letters shall be retained in the medical management system and the Member's Medical Record, in accordance with CalOptima Policy GG.1603: Medical Record Maintenance.

E. CalOptima shall monitor Health Network compliance with this ~~policy~~Policy in accordance with CalOptima ~~Policies~~Policy GG.1619: Delegation Oversight.

IV. ATTACHMENT(S)

A. ~~Utilization and Resource Management Program Description:~~ Timeframes for Decisions and Notifications (Medi-Cal)
B. Timeframes for Decisions and Notifications (OneCare and OneCare Connect)

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Network Service Agreement
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. CalOptima Policy CMC.4002: Cultural and Linguistic Services
F. CalOptima Policy DD.2002: Cultural and Linguistic Services
~~D.~~G. CalOptima Policy GG.1508: Authorization and Processing of Referrals
~~E.~~H. CalOptima Policy GG.1510: Appeal Process ~~for Decisions Regarding Care and Services~~
~~F.~~I. CalOptima Policy GG.1603: Medical Record Maintenance
~~G.~~J. CalOptima Policy GG.1619: Delegation Oversight
~~H.A. CalOptima Three-Way Contract with the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect~~
K. CalOptima Policy MA.4002: Cultural and Linguistic Services

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~~I.~~L. CalOptima Utilization Management Program

M. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual – Chapter 4 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance

~~J.~~N. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~17-006~~21-011: Grievance and Appeal Requirements ~~and ,Revised~~ Notice ~~Templates,~~ and "Your Rights" ~~Attachments~~Templates (supersedes APL 17-006)

~~K.~~O. Department of HealthCare Services (DHCS) All Plan Letter (APL~~) 17-011~~) 21-004: Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act

~~L.~~P. Medi-Cal Provider Manual – Part 1: Medi-Cal Program and Eligibility, TAR Overview. Revised: 01/15/2021

~~M.~~ Title ~~22,~~28 of the California Code of Regulations (CCR~~), §§ 51003(c), 51014.~~) 1300.68(a)(1~~,~~) and ~~51014.~~(2

~~N.~~Q. ~~Title); and~~ 42~~, Code of Federal Regulations (~~ CFR~~), §§ 431.200, 431.201, 431.206(c)(2),~~ 438.~~404, 438.420, and 422.568-572~~400(b).

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/01/2013	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTIONS

None to Date

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VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/1997	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	05/01/1997	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/1999	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	05/01/1999	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2003	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	10/01/2003	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	07/01/2007	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2013	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	07/01/2017	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	10/01/2020	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ''clean claim'' at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals. 6. For a resident of a rural area with only one managed care plan, the denial of the Member's request to obtain services outside the network. 7. The denial of a Member's request to dispute financial liability.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.

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Term	Definition
Appeal	Medi-Cal: A ~~request by the Member, Member's Authorized Representative, or Provider for~~ review by CalOptima of an ~~Adverse Benefit Determination that involves~~adverse benefit determination, which includes one of the ~~delay, modification,~~following actions: 1. A denial~~,~~ or ~~discontinuation~~limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service~~.~~; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare~~/OneCare Connect~~: Any of the procedures that deal with the review of an adverse ~~Organization Determinations~~initial determination made by CalOptima on ~~a~~ health care ~~service a~~services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the ~~Covered Service,~~health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in ~~Title 42 of the Code of Federal Regulations, Section~~ 42 CFR §422.566(b~~). An Appeal may~~) and §423.566(b). These procedures include ~~Reconsideration by CalOptima and if necessary, the Independent Review Entity~~reconsideration or redetermination , a reconsideration by an independent review entity (IRE), ~~hearings before~~adjudication by an Administrative Law Judge (ALJ~~),~~) or attorney adjudicator, review by the ~~Departmental Appeals Board (DAB), the~~ Medicare Appeals Council (MAC~~) or a~~), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.

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Term	Definition
Authorized Representative/Legal Representative	Medi-Cal: A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting *in loco parentis* who have the authority under applicable law to make health care decisions on behalf of unemancipated minors ~~and as further described in CalOptima Policy HH.3009: Access by a Member's Authorized Representative.~~. OneCare: An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct, including CalOptima Direct-Administrative and CalOptima Community Network (CCN).
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.

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Term	Definition
Covered ~~Service~~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~~Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter ~~18~~(APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article ~~3.95~~.51, beginning with section ~~14127), for HHP Members with eligible physical chronic conditions and substance use disorders,~~14184.100), 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the contract with the Centers for Medicare & Medicaid Services (CMS). One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the ~~three-way agreement~~Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
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.

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Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
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.
Integrated Denial Notice (IDN)	Written notice required upon denial, in whole or in part, of a Member's request for coverage and upon discontinuation or reduction of a previously authorized course of treatment. (OneCare and OneCare Connect programs).

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Term	Definition
~~Medical Necessity/~~Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For ~~Medi-Cal~~ Members ~~receiving managed long-term services and supports (MLTSS),~~ under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of 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~~Section 1396d(r~~) and California Welfare~~)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and ~~Institutions~~W&I Code ~~section~~Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: 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. 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 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~~Medically Necessary under 42 U.S.C. § 1395y. In accordance with Title XIX law and related regulations, and per Medi-Cal, ~~medical necessity~~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.

For 20220307 BOD Review Only

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 & 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.
Member	A beneficiary enrolled in a CalOptima program.
Notice of Action (NOA)	Written notice ~~informing a Member~~ of ~~an Adverse Benefit Determination.~~ any action within the timeframes for each type of action as provided by 42 C.F.R. § 438.404 and 422.568.
Practitioner	A licensed independent Practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Prescribing Practitioner	The physician, osteopath, podiatrist, dentist, optometrist or authorized mid-level medical Practitioner who prescribes a medication for a Member.
Primary Care ~~Provider/~~Practitioner/Physician (PCP)	A Practitioner/Physician responsible for supervising, coordinating, and providing initial and primary care to Members and serves as the medical home for Members. The PCP is a general Practitioner, internist, pediatrician, family Practitioner, or obstetrician/gynecologist (OB/GYN). For Members who are Seniors or Persons with Disabilities or eligible for the Whole Child Model, "Primary Care Practitioner" or "PCP" shall additionally mean any ~~Specialist Physician~~ Specialty Care Provider who is a Participating Provider and is willing to perform the role of the PCP. A PCP may also be a ~~non~~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 ~~specialist~~Specialty Care Provider or clinic ~~in accordance with W & I Code 14182(b)(11).~~.

For 20220302 POD Review Only

Term	Definition
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval ~~to provide specific~~of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare & OneCare Connect: A process through which a physician or ~~procedures~~other health care provider is required to obtain advance approval, from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Prior Authorization Notification	For the purposes of this policy, a written notification giving prior approval to provide and receive reimbursement for a Covered Service, equipment or supplies.
State Hearing	Medi-Cal: A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to Appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge. OneCare Connect: A quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits.
Threshold Language	Medi-Cal~~/OneCare Connect~~: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A Threshold Language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program. OneCare Connect: As specified in annual guidance to CalOptima on specific translation requirements for their service areas.

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Policy:	GG.1507
Title:	**Notification Requirements for Covered Services Requiring Prior Authorization**
Department:	Medical Management
Section:	Utilization Management
Interim CEO Approval:	*/s/*
Effective Date:	02/01/1997
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☒ OneCare ☒ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy establishes guidelines by which CalOptima and its Health Networks shall notify a Member, Member's Authorized Representative, Prescribing Practitioner, and Primary Care Practitioner (PCP), when a request for Prior Authorization of a Covered Service is processed.

II. POLICY

A. CalOptima and its Health Networks shall process and authorize requests for Prior Authorization in accordance with CalOptima Policy GG.1508: Authorization and Processing of Referrals.

B. CalOptima or a Health Network shall notify a Member, the Member's Authorized Representative, Prescribing Practitioner, and PCP, as appropriate, if:

1. CalOptima or the Health Network denies, modifies, or delays a request for Prior Authorization for a Covered Service requiring Prior Authorization; or

2. CalOptima or the Health Network terminates a previously approved Covered Service.

C. CalOptima or a Health Network shall notify a Member, the Member's Authorized Representative, Prescribing Practitioner, and PCP, as appropriate, with a written Notice of Action (NOA), applicable for Medi-Cal Members; or Integrated Denial Notice (IDN), applicable to OneCare and OneCare Connect Members.

D. NOAs and IDNs shall comply with contractual, State, and Federal requirements, as found in section 51014.1 of Title 22 of the California Code of Regulations, CalOptima's Contract for Health Care Services with its Health Networks, Department of Health Care Services (DHCS) All Plan Letter 21-011: Grievance and Appeal Requirements, Notice and "Your Rights" Templates, and in the Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual – Chapter 4 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.

E. CalOptima or a Health Network shall send a NOA or IDN in a timely manner, in accordance with the timelines set forth in Attachments A and B to this Policy, and in compliance with the language

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requirements of CalOptima Policies CMC.4002: Cultural and Linguistic Services, DD.2002: Cultural and Linguistic Services, and MA.4002: Cultural and Linguistic Services.

1. In providing NOAs and IDNs, CalOptima shall abide by the timing requirements for Medi-Cal service requests contained in Attachment A, and the requirements for Medicare (OneCare and OneCare Connect) service requests contained in Attachment B.

2. As provided in Attachments A and B, the timing in which NOAs and IDNs must be sent to the Member and providers shall be determined by the nature of the request (*e.g.*, expedited, routine) based on the Member's condition and may be affected by whether the provider submits all necessary information with the request.

F. CalOptima shall not be required to send a NOA or IDN if CalOptima approves a drug identical in chemical composition, dosage, and bioequivalence of a requested drug (*i.e.*, when a generic drug is substituted for the brand name drug).

G. A Health Network may delegate the notification requirements set forth in this Policy to a subcontracting medical group. In accordance with delegation oversight requirements, Health Networks shall be responsible for complying and ensuring subcontractors comply with all applicable state and federal laws and regulations, contract requirements, and CalOptima policies and procedures related to notification requirements for Covered Services requiring Prior Authorization.

H. Pursuant to requirements established by DHCS, CMS, and the National Committee on Quality Assurance (NCQA), and as reflected in the DHCS NOA and CMS IDN, a qualified CalOptima Medical Director shall review all medical and pharmacy denials, delays, and modifications for Medically Necessity, or benefit coverage in Prior Authorizations, concurrent reviews, and terminations.

III. PROCEDURE

A. CalOptima and a Health Network shall utilize the template NOA provided by DHCS or CMS, or equivalent language in the NOA or IDN.

1. The NOA and IDN shall include information on accessing interpretive services in Threshold Languages and information regarding accessing Teletype/Teletypewriter (TTY) services.

2. The NOA and IDN shall inform a Member of the Member's right to file for an Appeal for services covered by Medi-Cal, or an Independent Review for services covered by Medicare, upon receiving a notification of denial, delay, modification, reduction, suspension, or termination of Covered Services.

3. For Medi-Cal Covered Services, the NOA shall:

a. Contain a statement of the action CalOptima is taking on the request;

b. Describe the specific reason(s) for the decision in easy to understand language, and provide a reference and explanation of the CalOptima Prior Authorization guidelines or specific regulations on which the decision was based;

i. For decisions not based on Medical Necessity, the NOA shall provide a clear and concise explanation of the reasons for the decision.

ii. Decisions to deny services cannot be solely based on requested codes being listed as

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non-benefits (*i.e.*, in the Medi-Cal Treatment and Authorization (TAR) and Non-Benefit list of codes), and other reasons for the denial must be included in the NOA (*i.e.*, services were determined to be not Medically Necessary and/or did not meet other criteria considered).

c. Define how the Member, Prescribing Practitioner, or PCP can obtain a copy, free of charge, of the actual benefit provision, guideline, protocol, or other criteria on which the denial decision was based;

d. Describe the clinical reasons for the decision and explain how the Member's condition does not meet criteria or guidelines;

e. Inform the Prescribing Practitioner or PCP of the availability of an appropriate Practitioner to discuss the decision and provide contact instructions, including the name and direct telephone number of the healthcare professional responsible for the denial, delay, or modification to allow the Prescribing Practitioner or PCP to easily contact the healthcare professional responsible for the denial, delay, or modification;

f. Include a "Your Rights" attachment that contains general information regarding the Member and Prescriber Practitioner's or PCP's standard and expedited Appeal rights, an explanation of the Appeal process, and instructions on how to submit an Appeal, an explanation and instructions for the State Hearing process, and the right and how to request continuation of Covered Services, along with the nondiscrimination notice and language assistance taglines; and

g. Explain that the Member, Prescribing Practitioner or PCP can provide written comments, documents, or other information to Appeal the denial.

h. If CalOptima or a Health Network terminates an authorization for an ongoing service, CalOptima or a Health Network shall send the NOA at least ten (10) calendar days prior to the date of the termination.

4. For Medicare covered services, the IDN shall:

a. Include a specific and detailed explanation of why the medical services, items or Part B drugs were denied, including a description of the applicable coverage rule or applicable plan policy (*e.g.*, Evidence of Coverage provision) upon which the action was based, and a specific explanation about what information is needed to approve coverage must be included, if applicable;

b. Provide information regarding a Member's right to Appeal and the right to appoint a representative to file an Appeal on the Member's behalf;

c. For service denials, include a description of both the standard and expedited appeal processes, including the specific department or address for reconsideration requests and a description of conditions for obtaining an expedited reconsideration, the timeframes for each, and the other elements of the appeals process;

d. Explain that the Member has a right to submit additional evidence in writing or in person; and

e. Include an explanation of a provider's refusal to furnish an item, service, or Part B drug (if applicable).

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5. CalOptima or a Health Network shall communicate to the Prescribing Practitioner or PCP, a decision to approve, modify, or deny an authorization prior to, or concurrent with the provision of a Covered Service within twenty-four (24) hours of the decision.

B. Continuation of Benefits Pending an Appeal for Medi-Cal and OneCare Connect Covered Services

1. If CalOptima or a Health Network terminates an authorization for an ongoing service, the Member has a right to request continuation of benefits for Medi-Cal and OneCare Connect Covered Services by filing an Appeal within ten (10) calendar days after the date of the mailing of the NOA or IDN, as applicable, or the last date on which services were authorized under the immediately preceding authorization, whichever is later, in accordance with CalOptima Policy GG.1510: Appeal Process.

2. Upon notification that the Member timely requested an Appeal, CalOptima or a Health Network shall authorize continuing services from the date that the previous authorization expired.

3. The authorization shall not be at a level of service greater in amount, or frequency, than approved by the immediately preceding authorization.

4. The authorization period shall be determined according to the following:

a. Acute Care Continuing Services: The authorization shall be valid until the date an Appeal or State Hearing decision is rendered, the date on which an Appeal is withdrawn or closed, the date the treating Practitioner documents that the Member is ready for a lower level of care, or the date of discharge, whichever is earliest.

b. Non-Acute Continuing Services: The authorization shall be valid up to and including the date the Continuing Services were requested by the treating Practitioner, the date an Appeal or State Hearing decision is rendered, or the date on which the hearing Appeal is withdrawn or closed, whichever is earliest.

5. If the Member requests a continuation of services more than ten (10) calendar days after the date of the mailing or hand delivery of the NOA or IDN, or after the last date on which services were authorized under the immediately preceding authorization, whichever is later, CalOptima or a Health Network shall send the Member a Notice of Appeal Resolution (NAR) or IDN stating that the request for continued services is denied.

C. Aid Paid Pending a State Hearing for Medi-Cal and OneCare Connect Covered Services

1. To receive continuing service, a Member shall request a State Hearing within ten (10) calendar days after the date of the mailing of the NAR or Appeal resolution IDN, or the last date on which services were authorized under the immediately preceding authorization, whichever is later.

2. Upon timely filing a State Hearing requesting Aid Paid Pending, a Member may be eligible for continuation of benefits in accordance with Section III.B. of this Policy.

D. File copies of all notification letters shall be retained in the medical management system and the Member's Medical Record, in accordance with CalOptima Policy GG.1603: Medical Record Maintenance.

E. CalOptima shall monitor Health Network compliance with this Policy in accordance with CalOptima Policy GG.1619: Delegation Oversight.

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IV. ATTACHMENT(S)

A. Timeframes for Decisions and Notifications (Medi-Cal)
B. Timeframes for Decisions and Notifications (OneCare and OneCare Connect)

V. REFERENCE(S)

A. CalOptima Contract with the Centers for Medicare & Medicaid Services (CMS) for Medicare Advantage
B. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
C. CalOptima Health Network Service Agreement
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. CalOptima Policy CMC.4002: Cultural and Linguistic Services
F. CalOptima Policy DD.2002: Cultural and Linguistic Services
G. CalOptima Policy GG.1508: Authorization and Processing of Referrals
H. CalOptima Policy GG.1510: Appeal Process
I. CalOptima Policy GG.1603: Medical Record Maintenance
J. CalOptima Policy GG.1619: Delegation Oversight
K. CalOptima Policy MA.4002: Cultural and Linguistic Services
L. CalOptima Utilization Management Program
M. Centers for Medicare & Medicaid Services (CMS) Medicare Managed Care Manual – Chapter 4 and Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance
N. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011: Grievance and Appeal Requirements, Notice, and "Your Rights" Templates (supersedes APL 17-006)
O. Department of HealthCare Services (DHCS) All Plan Letter (APL) 21-004: Standards for Determining Threshold Languages and Requirements for Section 1557 of the Affordable Care Act
P. Medi-Cal Provider Manual – Part 1: Medi-Cal Program and Eligibility, TAR Overview. Revised: 01/15/2021
Q. Title 28 of the California Code of Regulations (CCR) 1300.68(a)(1) and (2); and 42 CFR 438.400(b).

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
02/01/2013	Department of Health Care Services (DHCS)	Approved as Submitted
02/24/2013	Department of Health Care Services (DHCS)	Approved as Submitted
06/13/2016	Department of Health Care Services (DHCS)	Approved as Submitted

VII. BOARD ACTIONS

None to Date

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	02/01/1997	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal

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Action	Date	Policy	Policy Title	Program(s)
Revised	05/01/1997	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/1999	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	05/01/1999	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2003	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	10/01/2003	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	07/01/2007	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2013	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal
Revised	01/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	08/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	12/01/2016	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	07/01/2017	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	12/01/2017	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	10/01/2019	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	10/01/2020	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect
Revised	TBD	GG.1507	Notification Requirements for Covered Services Requiring Prior Authorization	Medi-Cal OneCare OneCare Connect

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IX. GLOSSARY

Term	Definition
Adverse Benefit Determination	Any of the following actions: 1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit. 2. The reduction, suspension, or termination of a previously authorized service. 3. The denial, in whole or in part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ‘‘clean claim’’ at 42 CFR section 447.45(b) is not an Adverse Benefit Determination. 4. The failure to provide services in a timely manner. 5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals. 6. For a resident of a rural area with only one managed care plan, the denial of the Member’s request to obtain services outside the network. 7. The denial of a Member’s request to dispute financial liability.
Aid Paid Pending	Continuation of Covered Services for a Member who has filed a timely request for a State Hearing as a result of a Notice of Adverse Benefit Determination of intent to terminate, suspend, or reduce an existing authorized service.

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Term	Definition
Appeal	Medi-Cal: A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b). OneCare: Any of the procedures that deal with the review of an adverse initial determination made by CalOptima on health care services or benefits under Part C or D the Member believes he or she is entitled to receive, including a delay in providing, arranging for, or approving the health care services or drug coverage (when a delay would adversely affect the health of the Member), or on any amounts the Member must pay for a service or drug as defined in 42 CFR §422.566(b) and §423.566(b). These procedures include reconsideration or redetermination , a reconsideration by an independent review entity (IRE), adjudication by an Administrative Law Judge (ALJ) or attorney adjudicator, review by the Medicare Appeals Council (MAC), and judicial review. OneCare Connect: In general, a Member's actions, both internal and external to CalOptima requesting review of CalOptima's denial, reduction or termination of benefits or services, from CalOptima. Appeals relating to Medi-Cal covered benefits and services shall proceed pursuant to the laws and regulations governing Medi-Cal Appeals. Appeals relating to Medicare covered benefits and services shall proceed pursuant to the laws and regulations governing Medicare Appeals. A Medi-Cal based Appeal is defined as review by CalOptima of an Adverse Benefit Determination.

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Term	Definition
Authorized Representative/Legal Representative	Medi-Cal: 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: An individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the State in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request; e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity (see §40.2.1). Form CMS-1696 may not be used to appoint an authorized representative for the purposes of enrollment and disenrollment. This form is solely for use in the claims adjudication or claim appeals process, and does not provide broad legal authority to make another individual's healthcare decisions. OneCare Connect: An individual either appointed by a Member or authorized under State or other applicable law to act on behalf of the Member in filing a Grievance, requesting a Prior Authorization request, or in dealing with any level of the Appeals process. Unless otherwise stated in Title 42 of the Code of Federal Regulations, Part 423, Subpart M, the representative has all of the rights and responsibilities of a Member in obtaining a Prior Authorization request or in dealing with any of the levels of the Appeals process, subject to the rules described in Part 422, Subpart M.
CalOptima	For purposes of this policy, CalOptima means CalOptima Direct, including CalOptima Direct-Administrative and CalOptima Community Network (CCN).
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.

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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, 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 Enhanced Care Management and Community Supports as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative (as set forth in the CalAIM 1115 Demonstration & 1915(b) Waiver, DHCS All Plan Letter (APL) 21-012: Enhanced Care Management Requirements and APL 21-017: Community Supports Requirements, and Welfare and Institutions Code, Division 9, Part 3, Chapter 7, Article 5.51, beginning with section 14184.100), 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. OneCare: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the contract with the Centers for Medicare & Medicaid Services (CMS). One Care Connect: Those medical services, equipment, or supplies that CalOptima is obligated to provide to Members under the Three-Way contract with the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS).
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.

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Term	Definition
Grievance	Medi-Cal: An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision. OneCare: An expression of dissatisfaction with any aspect of the operations, activities or behavior of a plan or its delegated entity in the provision of health care items, services, or prescription drugs, regardless of whether remedial action is requested or can be taken. OneCare Connect: Any complaint or dispute, other than one that constitutes an organization determination under 42 C.F.R. § 422.566 or other than an Adverse Benefit Determination under 42 C.F.R. § 438.400, expressing dissatisfaction with any aspect of the CalOptima's or Provider's operations, activities, or behavior, regardless of whether remedial action is requested pursuant to 42 C.F.R. § 422.561. (Possible subjects for Grievances include, but are not limited to, the quality of care or services provided and aspects of interpersonal relationships such as rudeness of a Provider or employee, or failure to respect the Member's rights). Also called a "Complaint."
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.
Integrated Denial Notice (IDN)	Written notice required upon denial, in whole or in part, of a Member's request for coverage and upon discontinuation or reduction of a previously authorized course of treatment. (OneCare and OneCare Connect programs).

For 20220303 BOD Review Only

Term	Definition
Medically Necessary or Medical Necessity	Medi-Cal: Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child. OneCare: 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. 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.
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 & 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.
Member	A beneficiary enrolled in a CalOptima program.
Notice of Action (NOA)	Written notice of any action within the timeframes for each type of action as provided by 42 C.F.R. § 438.404 and 422.568.

For 20220303 BOD Review Only

Term	Definition
Practitioner	A licensed independent Practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Prescribing Practitioner	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.
Prior Authorization	Medi-Cal: A formal process requiring a health care Provider to obtain advance approval of Medically Necessary Covered Services, including the amount, duration and scope of services, except in the case of an emergency. OneCare & OneCare Connect: A process through which a physician or other health care provider is required to obtain advance approval, from CalOptima and/or a delegated entity, that payment will be made for a service or item furnished to a Member.
Prior Authorization Notification	For the purposes of this policy, a written notification giving prior approval to provide and receive reimbursement for a Covered Service, equipment or supplies.
State Hearing	Medi-Cal: A quasi-judicial proceeding based upon administrative law and operated by the California Department of Social Services (DSS) which allows an avenue for Medi-Cal beneficiaries to Appeal eligibility determinations and specific denials of medical services under the Medi-Cal program. All testimony is submitted under oath, affirmation, or penalty of perjury. The claimant is not required to attend a hearing, but if the claimant will not be present, an Authorized Representative is required to attend on his or her behalf, unless the hearing is a rehearing or a further hearing. All documents submitted by either the claimant or the involved agency shall be made available to both parties. Documents provided to the claimant shall be free of charge. OneCare Connect: A quasi-judicial proceeding conducted by a judge, during which each hearing party may present arguments and evidence, including witness(es), and cross examine witness(es) against them, with respect to a decision regarding the availability or delivery of services or benefits.

For 20220303 BOD Review Only

Term	Definition
Threshold Language	Medi-Cal: Those languages identified based upon State requirements and/or findings of the Population Needs Assessment (PNA). OneCare: A Threshold Language is defined by CMS as the native language of a group who compromises five percent (5%) or more of the people served by the CMS Program. OneCare Connect: As specified in annual guidance to CalOptima on specific translation requirements for their service areas.

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For 20220303 BOD Review Only

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service*: Prospective or concurrent service requests where no extension is requested or needed *Non pharmacy requests	Approve, Modify or Deny within 5 working days[1] of receipt of "all information" reasonably necessary and requested to render a decision, and in all circumstances no later than 14 calendar days following receipt of request. "all information" means: Service requested (CPT/HCPC code and description), complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Electronic or written communication within 24 hours of making the decision. **Member:** ADVERSE DETERMINATIONS ONLY Written notice must be dated and postmarked within 2 working days of making the decision, not to exceed 14 calendar days from receipt of the request for service
Routine (Non-Urgent) Pre-Service (Deferral), Extension needed:* • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests the extension, or the Plan justifies a need for additional information and can demonstrate how the extension is in the member's best interest. There is reasonable likelihood that receipt of such information would lead to approval of the request. *	May extend up to an additional 14 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional Information Incomplete or Not Received** within the required timeframe, it will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires- not to exceed 28 days	**Extension – Practitioner:** Oral or electronic notification within 24 hours of making the decision to delay. **Practitioner/Member:** Written NOA "delay" notification within 14 days of receipt of the request for services. • The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. 3) The anticipated date when a decision will be rendered. .

[1] Working days = Monday through Friday excluding California State Holidays https ://www.ftb.ca.gov/aboutftb/holidays.shtml

For 02/2023 BOD Review Only

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Expedited Requests (Pre-Service)*: No extension requested or needed Requests where a provider indicates or the Plan determines that the standard timeframe 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	Approve, modify or deny the request within 72 hours from receipt of request	**Practitioner:** Oral or Electronic(fax) notification within 24 hours of making the decision not to exceed 72 hours from receipt of request **Member:** ADVERSE DETERMINATIONS ONLY Written notice within 72 hours of the receipt of the request for services.
Expedited Authorization (Pre-Service)*,Extension needed: Extension is allowed ***only*** if member or provider requests the extension or the Plan justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request.	May extend up to 14 calendar days upon expiration of the 72hour timeframe. **Additional Requested Information is Received:** A decision must be made within 24 hours of receipt of requested information. **Additional Information Incomplete or not Received:** It will be considered a denial and therefore constitutes an Adverse Benefit Determination on the date the timeframe expires.	**Practitioner/Member:** Written NOA "delay" notification within 72 hours of receipt of the request for services. The extension must include: 1. Justification for the delay ,specifying the information requested but not received or the expert reviewer to be consulted, or the additional examinations or tests required. 2. The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension 3. The anticipated date when a decision will be rendered.

For 20220303 BOD Review Only

Attachment A
TIMEFRAMES FOR MEDI-CAL DECISIONS AND NOTIFICATIONS

Type of Request	Decision	Notification Timeframes
Concurrent*: Concurrent review of treatment regimen already in place, (inpatient, ongoing ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.	**Practitioner / Member:** Oral or electronic notification within 24 hours of the decision, consistent with the urgency of the Member's medical condition and in accordance with Health and Safety Code Section 1367.01 (h)(3). **Practitioner / Member:** Written notice within 3 calendar days after the oral notification. For terminations, suspensions, or reductions of previously authorized services, Plans must notify beneficiaries at least ten days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.
Post-Service / Retrospective Review*: All necessary information received at time of the request.	Approve, modify or deny within 30 calendar days from receipt of information that is reasonably necessary to make a determination.	**Practitioner:** Written notice within 30 calendar days from receipt of request. **Member:** Adverse Determination Only within 30 days of receipt of request
Post-Service*: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information.	**Practitioner:** Written notice within 30 calendar days from receipt of the information necessary to make the determination. **Member:** Adverse Determination Only within 30 days of receipt of request

For 20220203 BOD Review Only

Type of Request	Decision	Notification Timeframes
	Additional Clinical Information Incomplete or Not Received: Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	
Hospice - Inpatient Care*:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Member** Adverse Determination Only**:** Written notice within 2 working days of making the decision.

For 20220303 BOD Review Only

Attachment B
TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service: No extension requested or needed	Within 5 working days of receipt of "all information" reasonably necessary to render a decision, and in all circumstances no longer than 14 calendar days. "all information" means: Complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice 2 working days of making the decision, not to exceed 14 calendar days from receipt of the request for Sservice.
Routine (Non-Urgent) Pre-Service (Deferral) Extension needed • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests and justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request. An extension ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	May extend up to an additional 14 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional Information Incomplete or Not Received** A written member notice of denial issued within 28 calendar days from the receipt of the original referral request.	**Extension - Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** • Written notice within 14 calendar days of receipt of request. The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. **Decision Notification After an Extension - Practitioner / Member:** Written notice within 2 working days of making the decision, not to exceed 28 calendar days from receipt of the request.

For 2022050 BOD Review Only

Type of Request	Decision	Notification Timeframes
Expedited Authorization (Pre-Service): No extension requested or needed Requests where provider indicates or the 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.	Approve, modify, or deny the request ~~W~~within 72 hours from receipt of request	**Practitioner:** Oral or electronic notification within 24 hours of making the decision not to exceed 72 hours from receipt of request. ~~Member – Medi-Cal:~~ ~~Written notification within 72 hours from receipt of request.~~ **Member OCC and OC Medicare ~~s~~Services Only~~—OCC~~:** Oral notification within 72 hours from receipt of request. **Practitioner/Member:** Written notice within 2 working

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Expedited Authorization (Pre-Service): **Extension needed** Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	May extend up to 14 calendar days upon expiration of the 72-hour timeframe. Notify practitioner and member using the "delay" template and insert specifics including ~~1) Jusitification~~Justification for the delay, information ~~about~~ that has not been received, what consultation is needed and/or the additional examination or testes required to make a decision ~~and the anticipated date on which a decision will be rendered.~~ 1. ~~2~~ 2. The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. 3. ~~The plan shall also include t~~The anticipated date when a decision will be rendered. **Additional Requested Information is Received:** A decision must be made within 1 working day of receipt of requested information. **Additional Information Incomplete or not Received** Any decision delayed beyond the timeframe limits is	**Practitioner:** Oral or electronic notification within 24 hours of making the decision, and no later than the expiration date of the extension. **Member - OCC and OC Medicare ~~s~~Services Only:** Oral notification within 2 working days from making the decision, and no later than the expiration date of the extension. **Practitioner/Member:** Written notice within 2 working days of making the decision.

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Type of Request	Decision	Notification Timeframes
Concurrent: Concurrent review of treatment regimen already in place, (inpatient, ongoing /ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.	**Practitioner / Member:** Oral or electronic notification within 24 hours of the request. **Practitioner/Member:** Written notice within 3 calendar days after the oral notification.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Within 30 calendar days from receipt of request.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of request.
Post-Service: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of the information necessary to make the determination.

For 20220303 BOD Review Only

Type of Request	Decision	Notification Timeframes
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** Written notice within 2 working days or making the decision.

For 20220303 BOD Review Only

Attachment B

TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect

Type of Request	Decision	Notification Timeframes
Routine (Non-Urgent) Pre-Service: No extension requested or needed	Within 5 working days of receipt of "all information" reasonably necessary to render a decision, and in all circumstances no longer than 14 calendar days. "all information" means: Complete clinical information from any external entity necessary to provide an accurate clinical presentation for services being requested.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner/Member:** Written notice 2 working days of making the decision, not to exceed 14 calendar days from receipt of the request for Service.
Routine (Non-Urgent) Pre-Service (Deferral) Extension needed • Additional clinical information required • Requires consultation by an expert reviewer • Additional examination or tests to be performed Extension is allowed ***only*** if member or provider requests and justifies the need for additional information and is able to demonstrate how the delay is in the interest of the member. There is reasonable likelihood that receipt of such information would lead to approval of the request. An extension ***must not*** be used to pend organization determinations while waiting for medical records from contracted providers.	May extend up to an additional 14 calendar days. **Additional Requested Information is Received:** A decision must be made within 5 working days of receipt of requested information, not to exceed 28 calendar days from receipt of the original referral request. **Additional Information Incomplete or Not Received** A written member notice of denial issued within 28 calendar days from the receipt of the original referral request.	**Extension - Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** • Written notice within 14 calendar days of receipt of request. The extension must include: 1) Justification for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension **Note:** The health plan must respond to an expedited grievance within 24 hours of receipt. **Decision Notification After an Extension - Practitioner / Member:** Written notice within 2 working days of making the decision, not to exceed 28 calendar days from receipt of the request.

For 2022 BOD Review Only

Attachment B
TIMEFRAMES FOR DECISIONS AND NOTIFICATIONS OneCare and OneCare Connect

Type of Request	Decision	Notification Timeframes
Expedited Authorization (Pre-Service): No extension requested or needed Requests where provider indicates or the 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.	Approve, modify, or deny the request within 72 hours from receipt of request	**Practitioner:** Oral or electronic notification within 24 hours of making the decision not to exceed 72 hours from receipt of request. **Member OCC and OC Medicare Services Only:** Oral notification within 72 hours from receipt of request. **Practitioner/Member:** Written notice within 2 working days of making the decision.

For 20220303 BOD Review Only

Expedited Authorization (Pre-Service): **Extension needed** Requests where provider indicates or the Plan determines that the standard timeframes could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.	May extend up to 14 calendar days upon expiration of the 72-hour timeframe. Notify practitioner and member using the "delay" template and insert specifics including 1. Justification for the delay, information that has not been received, what consultation is needed and/or the additional examination or testes required to make a decision 2. The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. 3. The anticipated date when a decision will be rendered. **Additional Requested Information is Received:** A decision must be made within 1 working day of receipt of requested information. **Additional Information Incomplete or not Received** Any decision delayed beyond the timeframe limits is considered a denial and must be processed immediately as such.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision, and no later than the expiration date of the extension. **Member - OCC and OC Medicare Services Only:** Oral notification within 2 working days from making the decision, and no later than the expiration date of the extension. **Practitioner/Member:** Written notice within 2 working days of making the decision.

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Type of Request	Decision	Notification Timeframes
Concurrent: Concurrent review of treatment regimen already in place, (inpatient, ongoing /ambulatory services). In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient. **CA H&SC 1367.01 (h)(3)**	Within 5 working days or less, consistent with urgency of member's medical condition. The decision, based on medical necessity, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 5 business days from the plan's receipt of the information reasonably necessary, and requested by the plan to make the determination.	**Practitioner / Member:** Oral or electronic notification within 24 hours of the request. **Practitioner/Member:** Written notice within 3 calendar days after the oral notification.
Post-Service / Retrospective Review: All necessary information received at time of the request.	Within 30 calendar days from receipt of request.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of request.
Post-Service: Extension needed	**Additional Clinical Information Required (Deferral):** Decision to defer must be made as soon as the plan is aware that additional information is required to render a decision, but no more than 30 days from the receipt of the request. **Additional Information Received:** If requested information is received, decision must be made within 30 calendar days from receipt of request for information. **Additional Clinical Information Incomplete or Not Received:** Decision must be made with the information that is available by the end of the 30th calendar day given to provide the additional information.	**Practitioner / Member:** Written notice within 30 calendar days from receipt of the information necessary to make the determination.

For 20220503 BOD Review Only

Type of Request	Decision	Notification Timeframes
Hospice - Inpatient Care:	Within 24 hours of making the decision.	**Practitioner:** Oral or electronic notification within 24 hours of making the decision. **Practitioner / Member:** Written notice within 2 working days or making the decision.

For 20220303 BOD Review Only

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

18. Approve Proposed Changes to the CalOptima Medical Affairs Policies related CalAIM Enhanced Care Management and Community Supports.

Contacts

Kelly Giardina, MSG, CCM, Executive Director, Clinical Operations, (657) 900-1013
Sloane Petrillo, RN, BSN, PHN, CCM, Director, Case Management, (657) 900-1091

Recommended Action(s)

Recommend approval of proposed changes to four (4) Medical Affairs CalAIM policies.

Background

Following the initial January 1, 2022, implementation of ECM and Community Supports, CalOptima is updating CalAIM policies to reflect the following changes:

- Remove language specific to health networks as ECM providers
- Increase length of presumptive eligibility to ensure access to care
- Support Continuity of Care and Services between Managed Care Plans
- Expand access for Justice involved Population of Focus to begin January 1, 2022
- Added language to reflect additional community supports in preparation for future offerings

Discussion

CalOptima revised four (4) CalAIM clinical policies ***[GG.1353, GG.1354, GG.1355, and GG.1356]*** previously approved by the Board of Directors on December 20, 2021. Below section outlines the descriptions of the impacted policies followed by a list of substantive changes. The list does not include the non-substantiative changes reflected in individual policy redlines.

1. The ECM provider language updates ensure adequate care coverage and expands ECM providers coverage as appropriate and is reflected in all clinical policies:

Policy Section	Proposed Changes	Rationale
1353: Section III.F.1 and Section III.F.2 **1354: Section** II.D.2	Replace "CalOptima or a Health Network" to "ECM Provider" where appropriate.	CalOptima to use more general language to describe ECM provider.
1356: Section II.B.1	Remove "All contracted" at the beginning of the sentence.	CalOptima to use more general language to describe ECM provider.
Glossary:**1353, 1354, 1355, 1356**	Update all policies "ECM Provider"	Align with other CalAIM related policies.

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2. CalOptima is increasing presumptive eligibility for Recuperative care services from three (3) to fourteen (14) days to support access to care for CalOptima's most vulnerable members.

Policy Section	Proposed Changes	Rationale
1355: Section III.I.4.c	Update the presumptive eligibility period for recuperative care services from (3) to (14) days.	Expand presumptive eligibility for Members to receive timely recuperative care services.

3. CalOptima has established continuity of care protocols for members who transition from other Managed Care Plans to ensure appropriate services are in place and policies reflect protocol and are in compliance with regulatory guidance.

Policy Section	Proposed Changes	Rationale
1354: Section III.D	Add "Members transitioning from other Medi-Cal Managed Care Plans (MCPs) who were previously identified and receiving ECM services will be automatically authorized to received ECM services."	New DHCS guidelines received 12/31/21.

4. The policies now reflect CalOptima's expansion of ECM Population of Focus to include Justice involved individuals effective January 1, 2022, to reflect revised regulatory guidance.

Policy Section	Proposed Changes	Rationale
1355: Section II.A.1, Section III.E.2 a-c	Move Members transitioning from incarceration (adults and children/youth) to January 1, 2022.	DHCS MOC Amendment to add Justice-Involved (December 2021).

5. Finally, all policies were updated to include community supports for future consideration of offerings if CalOptima elects to proceed with these services upon future Board approval.

Policy Section	Proposed Changes	Rationale
1355: Section II.I	Add: In the event that CalOptima expands Community Supports, the following services listed below will be considered and are defined in Attachment A of this Policy. • Short-Term Post-Hospitalization Housing; • Medically-Tailored meals; • Sobering Centers; • Personal Care/Homemaker Services; and • Day Habilitation Program • Respite Services; • Nursing Facility Transition/Diversion to Assisted	Future Consideration of CalOptima adding additional Community supports based on regulatory requirements and board approval.

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	Living Facilities (Elderly and Adult Residential Facilities); • Community Transition Services/Nursing Facility Transition to a Home; • Environmental Accessibility Adaptions (Modifications); and Asthma Remediation.	

These modifications to the four (4) CalAIM clinical policies ensure that CalOptima is in compliance with new DHCS guidance provided on 12/31/21, for Enhanced Case Management and Community Supports authorizations and services, and all regulatory, contractual and operational guidelines.

Fiscal Impact

The recommended action to revise CalOptima Policies GG.1353, GG.1354, GG.1355 and GG.1356 is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget. Management will include revenue and expenses related to the ECM benefit, and current and future board and DHCS-approved Community Supports services in upcoming operating budgets.

Rationale for Recommendation

The recommended actions will ensure CalOptima is compliant with contractual and regulatory guidance provided by its regulators (e.g., Department of Health Care Services and Centers for Medicare & Medicaid Services). The recommended changes update the ECM Provider references and include new DHCS guidance on authorizations and services. The updated policies will supersede the prior versions.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. CalOptima Policy GG.1353 Enhanced Care Management Service Delivery
2. CalOptima Policy GG.1354 Enhanced Care Management Eligibility and Outreach
3. CalOptima Policy GG.1355 Community Supports
4. CalOptima Policy GG.1356 Enhanced Care Management Administration
5. California Advancing & Innovating Medi-Cal Proposal
6. DHCS All Plan Letter 21-017: Community Supports Requirements
7. DHCS All Plan Letter 21-012: Enhance Care Management Requirements
8. CalAIM Enhanced Care Management Policy Guide
9. DHCS-Community-Supports-Policy-Guide-December-12.30.21
10. CalAIM Updated ECM Guidance: Authorization Process and Continuity of Care Requirements (COC) for ECM 12/31/21.
11. DHCS MOC Amendment Justice Involved (December 2021)
12. 2022-B Final Draft for Community Supports Contract Language

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Board Action(s)

Board Meeting Dates	Action	Not to Exceed Amount
December 20, 2021	CalOptima Board Action previously approved Medical Affairs policies: GG.1353, GG.1354, GG.1355, GG.1356	

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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Policy:	GG.1353
Title:	**Enhanced Care Management Service Delivery**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220303 BOD Review Only

I. PURPOSE

This policy describes the process for provision of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative.

II. POLICY

A. CalOptima shall implement ECM in three (3) phases for Populations of Focus, as prescribed by the Department of Health Care Services (DHCS) and in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

B. CalOptima shall transition Health Homes Program (HHP) and Whole Person Care (WPC) to Enhanced Care Management under CalAIM no sooner than January 1, 2022.

C. An ECM Provider shall:

1. Conduct outreach and engagement services to all ECM-eligible Members for ECM services in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach;

2. Assign each Member enrolled in ECM a Lead Care Manager (LCM), with responsibility for interacting directly with the Member and/or family, Authorized Representative, caretakers, and/or other authorized support person(s), as appropriate;

3. Ensure accurate and up-to-date member-level records in their Medical Management System (MMS) for Members authorized for ECM;

4. Ensure all ECM Members receive all ECM core service components described below:

   a. Outreach and engagement;

   b. Comprehensive assessment and care management plan;

   c. Enhanced coordination of care;

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d. Health promotion;

e. Comprehensive transitional care;

f. Member and family supports; and

g. Coordination of and referral to community and social support services.

5. Ensure ECM Members are able to decline or discontinue ECM upon initial outreach and engagement, or at any other time;

6. Discontinue ECM for Members when case closure criteria are met;

7. Re-evaluate eligibility for ECM every six (6) months, and re-authorize ECM, if appropriate; and

8. An ECM Provider shall assign an LCM to each Member, with expertise and skills to meet each Member's needs.

D. CalOptima Member eligibility for participation in ECM shall be determined in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

E. CalOptima shall conduct oversight of ECM Providers in accordance with CalOptima Policy GG.1356: Enhanced Care Management Administration.

F. A Member or Provider shall be entitled to appeals and grievance procedures in accordance with CalOptima Policies HH.1101: CalOptima Provider Complaint, HH.1102: Member Grievance, HH.1103: CalOptima Health Network Member Grievance and Appeal Process, GG.1510: Appeal Process, and HH.1108: State Hearing Process and Procedures, as applicable.

III. PROCEDURE

A. Enhanced Care Management (ECM) Lead Care Manager (LCM)

1. An ECM Provider shall assign each Member enrolled in ECM an ECM LCM, with responsibility for interacting directly with the Member and/or family, Authorized Representative, caretakers, and/or other authorized support person(s), as appropriate.

a. An ECM Provider shall document the ECM LCM in its MMS;

b. The ECM LCM shall be responsible for engaging with a multi-disciplinary care team to:

i. Identify gaps in the ECM Member's care;

ii. Ensure appropriate input is obtained to effectively coordinate all primary, medical, behavioral, developmental, and oral health needs, Long Term Services and Supports (LTSS), Community Supports offered by CalOptima, and other services that address Social Determinants of Health regardless of setting, at a minimum;

iii. Develop a Person-Centered Plan of Care built around Member goals, needs, and choices including:

a) Member-centric goals;

b) Measurable outcomes; and

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c) Interventions to achieve Member goals.

iv. Ensure the Person-Centered Plan of Care is updated as a Member's needs change and goals are achieved or altered.

c. The multi-disciplinary care team may be composed of the ECM Member, authorized support person, ECM LCM, primary care provider, specialty medical providers, Community Supports Providers, and providers of other disciplines, and/or other authorized individuals per the Member's needs and choice.

B. ECM Provider Responsibilities

1. An ECM Provider shall ensure that accurate and up-to-date Member-level records related to the provision of ECM services are maintained in their MMS, in accordance with CalOptima Policy GG.1301: Comprehensive Care Management, for Members authorized for ECM, including:

a. Documentation of Member outreach attempts;

b. Documentation of Member assessments;

c. Member care plan; and

d. Care management notes.

2. An ECM Provider shall ensure all ECM Members receive all ECM core service components described below:

a. Outreach and Engagement

i. The ECM Provider is responsible for reaching out and engaging ECM-eligible Members in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach;

b. Comprehensive Assessment and Care Management Plan

i. ECM shall be provided primarily through in-person contact, in a Culturally Competent manner.

a) When in-person communication is not available or does not meet the ECM Member's needs, the ECM Provider shall use alternative methods, such as Telehealth or telephonic communication, to provide culturally appropriate and accessible communication in accordance with Member choice and availability;

b) An ECM Provider may implement telephonic and video call assessments and follow-up contact, in compliance with CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services, DHCS All Plan Letter (APL) 19-009 (Revised): Telehealth Services Policy, and APL 20-004: Emergency Guidance for Medi-Cal Managed Care Plans Health Plans in Response to COVID-19, including subsequent revisions of such APLs.

ii. The ECM Provider shall conduct a CalOptima-approved comprehensive assessment focused on identifying medical, psychosocial, and dental needs as well as Social

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Determinants of Health and gaps in care to inform the development of the Member-centric care plan.

iii. The ECM Provider shall develop a comprehensive, individualized, person-centered care management plan with input from the ECM Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s), as appropriate, to assess Member strengths, risks, needs, goals, and preferences as well as make recommendations for service needs.

iv. The care plan will incorporate identified needs and strategies to address those needs, including, but not limited to:

a) Physical and developmental health;

b) Mental health;

c) Dementia;

d) Substance use disorder;

e) LTSS;

f) Oral health;

g) Palliative Care needs;

h) Necessary community based and social services; and

i) Housing.

v. The ECM Provider will reassess ECM Members' progress toward their goals on a regular basis at a frequency appropriate for the Member's individual progress, changes in needs, and/or as identified in the care management plan.

vi. The ECM Provider will ensure the care management plan is reviewed, maintained, and updated under appropriate clinical oversight.

c. Enhanced Coordination of Care

i. The ECM Provider will contact the ECM Member and/or support persons regularly to organize care plan activities as laid out in the care management plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's care management plan.

ii. The ECM Provider will maintain regular contact with all providers that are identified as being part of the ECM Member's multi-disciplinary care team since their input is necessary for successful implementation of the Member's goals and needs. Enhanced coordination of care may include case conferences or other means of communication, as appropriate, in order to ensure that the Member's care is continuous and integrated among all service providers.

iii. The ECM Provider will work to ensure care is continuous and integrated among all service providers and refer to and follow up with primary care, physical and

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developmental health, mental health, SUD treatment, LTSS, oral health, Palliative Care, and necessary community-based and social services, including housing, as needed.

iv. The ECM Provider will engage the ECM Member in their treatment, including coordination for medication review and/or medication reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, as appropriate, and identifying and helping to address other barriers to Member engagement in treatment.

v. The ECM Provider will communicate the ECM Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.

vi. The ECM Provider will ensure regular contact with the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as appropriate, consistent with the care management plan and to ensure information is shared with all involved parties to monitor the ECM Member's conditions, health status, care planning, medications usages and side effects.

d. Health Promotion

i. The ECM Provider shall work with the ECM Member to identify and build on successes and potential family and/or support networks.

ii. The ECM Provider shall provide the ECM Member with services and coaching to encourage and support healthy lifestyle behavior choices, with the goal of creating self-sufficiency and supporting the Member's ability to successfully monitor and manage their health.

iii. The ECM Provider shall support the ECM Member in strengthening skills that enable the Member to identify and access resources to assist them in managing existing conditions and preventing the emergence of additional Chronic Health Conditions.

iv. The ECM Provider shall link ECM Members with resources for management and prevention of chronic conditions, self-help recovery resources, smoking cessation, and other services depending on Member's needs and preferences.

v. The ECM Provider shall use evidence-based practices, such as motivational interviewing, to engage and help the ECM Member participate in and manage their care.

e. Comprehensive Transitional Care

i. The ECM Provider shall work with the ECM Member and care team to develop strategies to reduce avoidable admissions and readmissions.

ii. For ECM Members who are experiencing or are likely to experience care transition, the ECM Provider shall ensure that comprehensive transitional care includes, but is not limited to:

a) Developing and regularly updating a transition plan for the ECM Member, including facilitating discharge instructions developed by a hospital discharge planner;

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b) Evaluating an ECM Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions across settings, including to, from, and among treatment facilities, including admissions and discharges;

c) Tracking each ECM Member's transitions, including admission and/or discharge, across settings, including emergency department, hospital inpatient facilities, skilled nursing facilities, residential or treatment facilities, incarceration facilities, or other treatment centers, and communicating with the appropriate multi-disciplinary care team members;

d) Coordinating of medication review and/or reconciliation; and

e) Providing adherence support and referral to appropriate services.

iii. The ECM Provider shall leverage technologies, tools, and services, as available, that can be deployed and used to provide real-time alerts that notify ECM and the multi-disciplinary care team members about care transitions (e.g., acute and subacute care facilities, emergency department, residential treatment facilities, and incarceration) and other critical health and social determinant status changes (e.g., housing and employment).

f. Member and Family Supports

i. The ECM Provider shall document the ECM Member's authorized family members, legal guardians, Authorized Representatives, caregivers, and/or other authorized support persons, as applicable.

ii. The ECM Provider shall ensure all required authorizations are in place to ensure effective communication between the ECM Provider, CalOptima, and the ECM Member and their family members, Authorized Representatives, legal guardians, caregivers, and authorized support persons, as applicable.

iii. The ECM Provider shall conduct activities, including educating the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as applicable, to ensure they are knowledgeable about the Member's conditions, with the goal of improving the Member's care planning and follow up, adherence to treatment regimens, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

iv. The ECM Provider shall ensure that the ECM Member's assigned ECM LCM serves as the primary point of contact for the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and other authorized support persons, as applicable.

v. The ECM Provider shall identify and assess the supports needed for the ECM Member and/or their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as applicable, to manage the Member's condition and assist them in accessing needed support services and with making informed choices.

vi. The ECM Provider shall provide for appropriate education for the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and/or authorized support persons regarding Member care instructions and needs.

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vii. The ECM Provider shall share a copy of the ECM Member's care management plan and information on the process for requesting updates with the ECM Member and, as appropriate and if the ECM Member is in agreement, with the ECM Member's legal guardians, Authorized Representatives, family members, caregivers, and authorized support persons, as applicable.

g. Coordination of and Referral to Community and Social Support Services

i. The ECM Provider shall determine appropriate community and social support services that are available to meet ECM Members' needs, including those that address Social Determinants of Health, such as housing support and other Community Supports offered by CalOptima.

ii. The ECM Provider shall coordinate and refer ECM Members to available community resources, and follow up with such Members to ensure that services were rendered and the Member is engaged with community service providers, as appropriate.

C. Discontinuation of ECM

1. An ECM Provider shall ensure ECM Members are able to decline or discontinue ECM upon initial outreach and engagement, or at any other time.

a. If a Member declines or requests to discontinue ECM at any time, the ECM Provider shall close the Member's ECM case.

2. An ECM Provider shall discontinue ECM for Members when any of the following case closure criteria are met and shall notify CalOptima via the monthly eligibility and activity file in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting:

a. The Member has met all care plan goals.

b. The Member is ready to transition to a lower level of care management.

c. The Member states they no longer wish to receive ECM.

d. The Member is unresponsive or unwilling to engage in care management. This can include instances when a Member's behavior or environment is unsafe for the ECM Provider.

~~a.~~e. The ECM Provider has not been able to connect with the Member after multiple attempts.

D. An ECM Provider shall re-evaluate that an ECM Member meets criteria for ECM every six (6) months and re-authorize ECM if appropriate.

1. The ECM Provider shall document authorization in the MMS.

E. For Members who have engaged in ECM services and no longer require this level of services, the ECM Provider will work with Member to agree on transition.

1. Member has met all care plan goals;

2. Member is ready to transition to a lower level of care management;

a. ECM Provider shall evaluate the Member to determine if the Member would benefit from a less intensive care management program.

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b. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program, as appropriate, and with Member agreement.

c. The ECM Provider shall transition the Member to the lower intensity program at CalOptima or the assigned Health Network, with warm handoff as available.

F. CalOptima shall transition HHP and WPC to ECM as part of the CalAIM initiative no sooner than January 1, 2022.

1. For Members enrolled in or in the process of being enrolled in the HHP on December 31, 2021, ~~CalOptima or a Health Network~~the ECM Provider shall begin the transition process as follows:

a. ~~A~~Except as provided in CalOptima Policy GG.1356: Enhanced Care Management Administration, a Member shall remain assigned to their assigned Health Network for receipt of ECM services unless the Member requests a change of Health Network in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

b. ~~CalOptima or a Health Network~~An ECM Provider shall maintain the established contact schedule for each enrolled Member.

c. At the next scheduled contact or within six (6) months of the ECM implementation date, whichever is earlier, the Member's ECM LCM shall perform a reassessment to determine the most appropriate level of care management for the Member and the need for Community Supports.

i. The ECM Provider shall evaluate the Member to confirm whether ECM or a less intensive level of care management best meets the Member's needs.

ii. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program as appropriate and with Member agreement.

iii. The LCM shall document the assessment and appropriateness for ECM, as well as the member notification of change of level of care management in the MMS.

d. ~~CalOptima or a Health Network~~An ECM Provider shall maintain the Member's previously assigned ECM LCM to the extent possible.

2. For WPC Members identified on the WPC Member Transition List, CalOptima or a Health Network shall authorize, and an ECM Provider shall initiate, ECM in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

a. An ECM Provider shall utilize information shared by Orange County, as available, to aid in outreach and create a smooth transition for the Member.

b. Within six (6) months of the ECM implementation date, the ECM Provider shall perform an assessment of the Member to determine the most appropriate level of care management for the Member and the need for Community Supports.

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i. The ECM Provider shall evaluate the Member to confirm whether ECM or a less intensive level of care management best meets the Member's needs.

ii. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program as appropriate and with Member agreement.

iii. The LCM shall document the assessment and appropriateness for ECM as well as Member notification of change of level of care management in the MMS.

c. ~~CalOptima or a Health Network~~ECM Provider shall receive warm handoffs from the WPC lead entity as available.

i. In the event a warm handoff from the lead entity is not available, ~~CalOptima or a Health Network~~an ECM Provider shall use data provided by the lead entity to provide a smooth transition to ECM services.

G. An ECM Provider shall assign an ECM LCM to each Member, with expertise and skills to meet each Member's needs.

1. ECM care managers shall complete training in accordance with GG.1356: Enhanced Care Management Administration.

2. An ECM Provider shall consider Member preference in the event a Member wishes to change their LCM.

a. If an ECM Member requests a new LCM, the ECM Provider shall consider the following factors in determining whether a new LCM will be assigned:

i. Member's clinical needs;

ii. Member's preferred language;

iii. Social and therapeutic considerations; and

iv. Staff availability.

b. If reassignment is appropriate and staff is available, the ECM Provider shall change the LCM.

c. If reassignment is not clinically appropriate, or staff is unavailable, the ECM Provider shall work with the Member and LCM to address the Member's concerns.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract Template Provisions
B. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and ~~In Lieu of Services (ILOS)~~Community Supports Model of Care Template

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C. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Policy Guide
D. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
E. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
F. CalOptima Policy GG.1301: Comprehensive Case Management Process
G. CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach
H. CalOptima Policy GG.1356: Enhanced Care Management Administration
I. CalOptima Policy GG.1510: Appeal Process
J. CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.1102: Member Grievance
M. CalOptima Policy HH.1103: CalOptima Health Network Member Grievance and Appeal Process
N. CalOptima Policy HH.1108: State Hearing Process and Procedures
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009 (Revised): Telehealth Services Policy
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-004: Emergency Guidance for Medi-Cal Managed Care Plans Health Plans in Response to COVID-19
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-012: Enhanced Care Management Requirements

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	**Regulatory Agency**	**Response**
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	**Meeting**
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	**Date**	**Policy**	**Policy Title**	**Program(s)**
Effective	01/01/2022	GG.1353	Enhanced Care Management Service Delivery	Medi-Cal
Revised	TBD	GG.1353	Enhanced Care Management Service Delivery	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member or 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.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of DHCS-approved Community Supports. Providers are entities with experience and expertise providing one (1) or more of the Community Supports approved by DHCS.
Cultural Competency or Culturally Competent	The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include: 1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of Members; 2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns; 3. Recognition of the diversity among Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status); 4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care; 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability; 6. Programs and policies that address the health needs of diverse Member populations; and 7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of Members.

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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.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Lead Care Manager (LCM)	The Lead Care Manager (LCM) is a Member's designated care manager for ECM, who works for the ECM Provider organization and in the case of CalOptima Direct (COD) serving as the ECM Provider, the LCM could be on staff with CalOptima. The LCM operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers or participates in other care management programs, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	Providers within the community that have a contractual relationship with CalOptima (such as a delegated Health ~~Networks and the County of Orange), or CalOptima acting directly (COD),~~Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
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.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

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Term	Definition
Person-Centered Plan of Care	An ongoing process designed to develop an individualized care plan specific to each person's needs, desires, and abilities. A Person-Centered Plan of Care includes consideration of the current and unique bio-psycho-social and medical history of the individual Member, as well as the Member's functional level, support systems and continuum of care needs. A Person-Centered Plan of Care is an integral part of basic and complex care management, ECM, and discharge planning.
Populations of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers; c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and f. Transitioning from incarceration.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

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Term	Definition
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Policy:	GG.1353
Title:	**Enhanced Care Management Service Delivery**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This policy describes the process for provision of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative.

II. POLICY

A. CalOptima shall implement ECM in three (3) phases for Populations of Focus, as prescribed by the Department of Health Care Services (DHCS) and in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

B. CalOptima shall transition Health Homes Program (HHP) and Whole Person Care (WPC) to Enhanced Care Management under CalAIM no sooner than January 1, 2022.

C. An ECM Provider shall:

1. Conduct outreach and engagement services to all ECM-eligible Members for ECM services in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach;

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   b. Comprehensive assessment and care management plan;

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e. Comprehensive transitional care;

f. Member and family supports; and

g. Coordination of and referral to community and social support services.

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6. Discontinue ECM for Members when case closure criteria are met;

7. Re-evaluate eligibility for ECM every six (6) months, and re-authorize ECM, if appropriate; and

8. An ECM Provider shall assign an LCM to each Member, with expertise and skills to meet each Member's needs.

D. CalOptima Member eligibility for participation in ECM shall be determined in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

E. CalOptima shall conduct oversight of ECM Providers in accordance with CalOptima Policy GG.1356: Enhanced Care Management Administration.

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III. PROCEDURE

A. Enhanced Care Management (ECM) Lead Care Manager (LCM)

1. An ECM Provider shall assign each Member enrolled in ECM an ECM LCM, with responsibility for interacting directly with the Member and/or family, Authorized Representative, caretakers, and/or other authorized support person(s), as appropriate.

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b. The ECM LCM shall be responsible for engaging with a multi-disciplinary care team to:

i. Identify gaps in the ECM Member's care;

ii. Ensure appropriate input is obtained to effectively coordinate all primary, medical, behavioral, developmental, and oral health needs, Long Term Services and Supports (LTSS), Community Supports offered by CalOptima, and other services that address Social Determinants of Health regardless of setting, at a minimum;

iii. Develop a Person-Centered Plan of Care built around Member goals, needs, and choices including:

a) Member-centric goals;

b) Measurable outcomes; and

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c) Interventions to achieve Member goals.

iv. Ensure the Person-Centered Plan of Care is updated as a Member's needs change and goals are achieved or altered.

c. The multi-disciplinary care team may be composed of the ECM Member, authorized support person, ECM LCM, primary care provider, specialty medical providers, Community Supports Providers, and providers of other disciplines, and/or other authorized individuals per the Member's needs and choice.

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1. An ECM Provider shall ensure that accurate and up-to-date Member-level records related to the provision of ECM services are maintained in their MMS, in accordance with CalOptima Policy GG.1301: Comprehensive Care Management, for Members authorized for ECM, including:

a. Documentation of Member outreach attempts;

b. Documentation of Member assessments;

c. Member care plan; and

d. Care management notes.

2. An ECM Provider shall ensure all ECM Members receive all ECM core service components described below:

a. Outreach and Engagement

i. The ECM Provider is responsible for reaching out and engaging ECM-eligible Members in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach;

b. Comprehensive Assessment and Care Management Plan

i. ECM shall be provided primarily through in-person contact, in a Culturally Competent manner.

a) When in-person communication is not available or does not meet the ECM Member's needs, the ECM Provider shall use alternative methods, such as Telehealth or telephonic communication, to provide culturally appropriate and accessible communication in accordance with Member choice and availability;

b) An ECM Provider may implement telephonic and video call assessments and follow-up contact, in compliance with CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services, DHCS All Plan Letter (APL) 19-009 (Revised): Telehealth Services Policy, and APL 20-004: Emergency Guidance for Medi-Cal Managed Care Plans Health Plans in Response to COVID-19, including subsequent revisions of such APLs.

ii. The ECM Provider shall conduct a CalOptima-approved comprehensive assessment focused on identifying medical, psychosocial, and dental needs as well as Social

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Determinants of Health and gaps in care to inform the development of the Member-centric care plan.

iii. The ECM Provider shall develop a comprehensive, individualized, person-centered care management plan with input from the ECM Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s), as appropriate, to assess Member strengths, risks, needs, goals, and preferences as well as make recommendations for service needs.

iv. The care plan will incorporate identified needs and strategies to address those needs, including, but not limited to:

a) Physical and developmental health;

b) Mental health;

c) Dementia;

d) Substance use disorder;

e) LTSS;

f) Oral health;

g) Palliative Care needs;

h) Necessary community based and social services; and

i) Housing.

v. The ECM Provider will reassess ECM Members' progress toward their goals on a regular basis at a frequency appropriate for the Member's individual progress, changes in needs, and/or as identified in the care management plan.

vi. The ECM Provider will ensure the care management plan is reviewed, maintained, and updated under appropriate clinical oversight.

c. Enhanced Coordination of Care

i. The ECM Provider will contact the ECM Member and/or support persons regularly to organize care plan activities as laid out in the care management plan, sharing information with those involved as part of the Member's multi-disciplinary care team, and implementing activities identified in the Member's care management plan.

ii. The ECM Provider will maintain regular contact with all providers that are identified as being part of the ECM Member's multi-disciplinary care team since their input is necessary for successful implementation of the Member's goals and needs. Enhanced coordination of care may include case conferences or other means of communication, as appropriate, in order to ensure that the Member's care is continuous and integrated among all service providers.

iii. The ECM Provider will work to ensure care is continuous and integrated among all service providers and refer to and follow up with primary care, physical and

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developmental health, mental health, SUD treatment, LTSS, oral health, Palliative Care, and necessary community-based and social services, including housing, as needed.

iv. The ECM Provider will engage the ECM Member in their treatment, including coordination for medication review and/or medication reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, as appropriate, and identifying and helping to address other barriers to Member engagement in treatment.

v. The ECM Provider will communicate the ECM Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care.

vi. The ECM Provider will ensure regular contact with the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as appropriate, consistent with the care management plan and to ensure information is shared with all involved parties to monitor the ECM Member's conditions, health status, care planning, medications usages and side effects.

d. Health Promotion

i. The ECM Provider shall work with the ECM Member to identify and build on successes and potential family and/or support networks.

ii. The ECM Provider shall provide the ECM Member with services and coaching to encourage and support healthy lifestyle behavior choices, with the goal of creating self-sufficiency and supporting the Member's ability to successfully monitor and manage their health.

iii. The ECM Provider shall support the ECM Member in strengthening skills that enable the Member to identify and access resources to assist them in managing existing conditions and preventing the emergence of additional Chronic Health Conditions.

iv. The ECM Provider shall link ECM Members with resources for management and prevention of chronic conditions, self-help recovery resources, smoking cessation, and other services depending on Member's needs and preferences.

v. The ECM Provider shall use evidence-based practices, such as motivational interviewing, to engage and help the ECM Member participate in and manage their care.

e. Comprehensive Transitional Care

i. The ECM Provider shall work with the ECM Member and care team to develop strategies to reduce avoidable admissions and readmissions.

ii. For ECM Members who are experiencing or are likely to experience care transition, the ECM Provider shall ensure that comprehensive transitional care includes, but is not limited to:

a) Developing and regularly updating a transition plan for the ECM Member, including facilitating discharge instructions developed by a hospital discharge planner;

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b) Evaluating an ECM Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions across settings, including to, from, and among treatment facilities, including admissions and discharges;

c) Tracking each ECM Member's transitions, including admission and/or discharge, across settings, including emergency department, hospital inpatient facilities, skilled nursing facilities, residential or treatment facilities, incarceration facilities, or other treatment centers, and communicating with the appropriate multi-disciplinary care team members;

d) Coordinating of medication review and/or reconciliation; and

e) Providing adherence support and referral to appropriate services.

iii. The ECM Provider shall leverage technologies, tools, and services, as available, that can be deployed and used to provide real-time alerts that notify ECM and the multi-disciplinary care team members about care transitions (e.g., acute and subacute care facilities, emergency department, residential treatment facilities, and incarceration) and other critical health and social determinant status changes (e.g., housing and employment).

f. Member and Family Supports

i. The ECM Provider shall document the ECM Member's authorized family members, legal guardians, Authorized Representatives, caregivers, and/or other authorized support persons, as applicable.

ii. The ECM Provider shall ensure all required authorizations are in place to ensure effective communication between the ECM Provider, CalOptima, and the ECM Member and their family members, Authorized Representatives, legal guardians, caregivers, and authorized support persons, as applicable.

iii. The ECM Provider shall conduct activities, including educating the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as applicable, to ensure they are knowledgeable about the Member's conditions, with the goal of improving the Member's care planning and follow up, adherence to treatment regimens, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

iv. The ECM Provider shall ensure that the ECM Member's assigned ECM LCM serves as the primary point of contact for the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and other authorized support persons, as applicable.

v. The ECM Provider shall identify and assess the supports needed for the ECM Member and/or their family members, legal guardians, Authorized Representatives, caregivers, and authorized support persons, as applicable, to manage the Member's condition and assist them in accessing needed support services and with making informed choices.

vi. The ECM Provider shall provide for appropriate education for the ECM Member and their family members, legal guardians, Authorized Representatives, caregivers, and/or authorized support persons regarding Member care instructions and needs.

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vii. The ECM Provider shall share a copy of the ECM Member's care management plan and information on the process for requesting updates with the ECM Member and, as appropriate and if the ECM Member is in agreement, with the ECM Member's legal guardians, Authorized Representatives, family members, caregivers, and authorized support persons, as applicable.

g. Coordination of and Referral to Community and Social Support Services

i. The ECM Provider shall determine appropriate community and social support services that are available to meet ECM Members' needs, including those that address Social Determinants of Health, such as housing support and other Community Supports offered by CalOptima.

ii. The ECM Provider shall coordinate and refer ECM Members to available community resources, and follow up with such Members to ensure that services were rendered and the Member is engaged with community service providers, as appropriate.

C. Discontinuation of ECM

1. An ECM Provider shall ensure ECM Members are able to decline or discontinue ECM upon initial outreach and engagement, or at any other time.

a. If a Member declines or requests to discontinue ECM at any time, the ECM Provider shall close the Member's ECM case.

2. An ECM Provider shall discontinue ECM for Members when any of the following case closure criteria are met and shall notify CalOptima via the monthly eligibility and activity file in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting:

a. The Member has met all care plan goals.

b. The Member is ready to transition to a lower level of care management.

c. The Member states they no longer wish to receive ECM.

d. The Member is unresponsive or unwilling to engage in care management. This can include instances when a Member's behavior or environment is unsafe for the ECM Provider.

e. The ECM Provider has not been able to connect with the Member after multiple attempts.

D. An ECM Provider shall re-evaluate that an ECM Member meets criteria for ECM every six (6) months and re-authorize ECM if appropriate.

1. The ECM Provider shall document authorization in the MMS.

E. For Members who have engaged in ECM services and no longer require this level of services, the ECM Provider will work with Member to agree on transition.

1. Member has met all care plan goals;

2. Member is ready to transition to a lower level of care management;

a. ECM Provider shall evaluate the Member to determine if the Member would benefit from a less intensive care management program.

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b. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program, as appropriate, and with Member agreement.

c. The ECM Provider shall transition the Member to the lower intensity program at CalOptima or the assigned Health Network, with warm handoff as available.

F. CalOptima shall transition HHP and WPC to ECM as part of the CalAIM initiative no sooner than January 1, 2022.

1. For Members enrolled in or in the process of being enrolled in the HHP on December 31, 2021, the ECM Provider shall begin the transition process as follows:

a. Except as provided in CalOptima Policy GG.1356: Enhanced Care Management Administration, a Member shall remain assigned to their assigned Health Network for receipt of ECM services unless the Member requests a change of Health Network in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

b. An ECM Provider shall maintain the established contact schedule for each enrolled Member.

c. At the next scheduled contact or within six (6) months of the ECM implementation date, whichever is earlier, the Member's ECM LCM shall perform a reassessment to determine the most appropriate level of care management for the Member and the need for Community Supports.

i. The ECM Provider shall evaluate the Member to confirm whether ECM or a less intensive level of care management best meets the Member's needs.

ii. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program as appropriate and with Member agreement.

iii. The LCM shall document the assessment and appropriateness for ECM, as well as the member notification of change of level of care management in the MMS.

d. An ECM Provider shall maintain the Member's previously assigned ECM LCM to the extent possible.

2. For WPC Members identified on the WPC Member Transition List, CalOptima or a Health Network shall authorize, and an ECM Provider shall initiate, ECM in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

a. An ECM Provider shall utilize information shared by Orange County, as available, to aid in outreach and create a smooth transition for the Member.

b. Within six (6) months of the ECM implementation date, the ECM Provider shall perform an assessment of the Member to determine the most appropriate level of care management for the Member and the need for Community Supports.

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i. The ECM Provider shall evaluate the Member to confirm whether ECM or a less intensive level of care management best meets the Member's needs.

ii. If the Member would benefit from a less intensive care management program, the care manager will come to an agreement with the Member regarding the appropriate level of care management support and will transition the Member to the less intensive program as appropriate and with Member agreement.

iii. The LCM shall document the assessment and appropriateness for ECM as well as Member notification of change of level of care management in the MMS.

c. ECM Provider shall receive warm handoffs from the WPC lead entity as available.

i. In the event a warm handoff from the lead entity is not available, an ECM Provider shall use data provided by the lead entity to provide a smooth transition to ECM services.

G. An ECM Provider shall assign an ECM LCM to each Member, with expertise and skills to meet each Member's needs.

1. ECM care managers shall complete training in accordance with GG.1356: Enhanced Care Management Administration.

2. An ECM Provider shall consider Member preference in the event a Member wishes to change their LCM.

a. If an ECM Member requests a new LCM, the ECM Provider shall consider the following factors in determining whether a new LCM will be assigned:

i. Member's clinical needs;

ii. Member's preferred language;

iii. Social and therapeutic considerations; and

iv. Staff availability.

b. If reassignment is appropriate and staff is available, the ECM Provider shall change the LCM.

c. If reassignment is not clinically appropriate, or staff is unavailable, the ECM Provider shall work with the Member and LCM to address the Member's concerns.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract Template Provisions
B. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and Community Supports Model of Care Template

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C. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Policy Guide
D. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
E. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
F. CalOptima Policy GG.1301: Comprehensive Case Management Process
G. CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach
H. CalOptima Policy GG.1356: Enhanced Care Management Administration
I. CalOptima Policy GG.1510: Appeal Process
J. CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services
K. CalOptima Policy HH.1101: CalOptima Provider Complaint
L. CalOptima Policy HH.1102: Member Grievance
M. CalOptima Policy HH.1103: CalOptima Health Network Member Grievance and Appeal Process
N. CalOptima Policy HH.1108: State Hearing Process and Procedures
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009 (Revised): Telehealth Services Policy
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 20-004: Emergency Guidance for Medi-Cal Managed Care Plans Health Plans in Response to COVID-19
Q. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-012: Enhanced Care Management Requirements

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1353	Enhanced Care Management Service Delivery	Medi-Cal
Revised	TBD	GG.1353	Enhanced Care Management Service Delivery	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member or 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.
Chronic Health Condition	A condition with symptoms present for three (3) months or longer. Pregnancy is not included in this definition.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of DHCS-approved Community Supports. Providers are entities with experience and expertise providing one (1) or more of the Community Supports approved by DHCS.
Cultural Competency or Culturally Competent	The ability to actively apply knowledge of cultural behavior and linguistic issues when interacting with members from diverse cultural and linguistic backgrounds. Essential elements of Cultural Competency include: 1. An unbiased attitude and organizational policy that values and respects cultural diversity and respect for the multifaceted nature and individuality of Members; 2. Awareness that culture and cultural beliefs may influence health and health care delivery; knowledge about, and respect for diverse attitudes, beliefs, behaviors, and practices about preventive health, illness and diseases, as well as differing communication patterns; 3. Recognition of the diversity among Members (e.g., religion, socioeconomic status, physical or mental ability, age, gender, sexual orientation, social and historical context, generational, and acculturation status); 4. Skills to communicate effectively with diverse Member populations and application of those skills in cross-cultural interactions to ensure equal access to quality health care; 5. Knowledge of disease prevalence in specific cultural populations, whether defined by race, ethnicity, socioeconomic status, physical or mental ability, gender, sexual orientation, age, or disability; 6. Programs and policies that address the health needs of diverse Member populations; and 7. Ongoing program and service delivery evaluation with regard to cultural and linguistic needs of Members.

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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.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Lead Care Manager (LCM)	The Lead Care Manager (LCM) is a Member's designated care manager for ECM, who works for the ECM Provider organization and in the case of CalOptima Direct (COD) serving as the ECM Provider, the LCM could be on staff with CalOptima. The LCM operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers or participates in other care management programs, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	Providers within the community that have a contractual relationship with CalOptima (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
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.
Palliative Care	Patient- and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

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Term	Definition
Person-Centered Plan of Care	An ongoing process designed to develop an individualized care plan specific to each person's needs, desires, and abilities. A Person-Centered Plan of Care includes consideration of the current and unique bio-psycho-social and medical history of the individual Member, as well as the Member's functional level, support systems and continuum of care needs. A Person-Centered Plan of Care is an integral part of basic and complex care management, ECM, and discharge planning.
Populations of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers; c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and f. Transitioning from incarceration.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

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Term	Definition
Telehealth	The mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a Member's health care while the Member is at the originating site, and the health care provider is at a distant site. Telehealth facilitates Member self-management and caregiver support for Members and includes synchronous interactions and asynchronous store and forward transfers.

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Policy:	GG.1354
Title:	**Enhanced Care Management - Eligibility and Outreach**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

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I. PURPOSE

This policy describes the implementation of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative, including the processes to identify eligible Members and conduct outreach activities.

II. POLICY

A. CalOptima shall implement ECM in three (3) phases for Populations of Focus, as prescribed by the Department of Health Care Services (DHCS):

1. No sooner than January 1, 2022: For Members experiencing Homelessness (adults and children/youth), adult high utilizers, and adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) and Members transitioning from incarceration (adults and children/youth) as described in Sections III.A.1.a.-c, and f. of this Policy;

2. No sooner than January 1, 2023: For Members eligible for Long Term Care (LTC) and who are at risk for institutionalization, and nursing facility residents transitioning to the community, ~~and Members transitioning from incarceration (adults and children/youth)~~ as described in Section III.A.1.d. ~~f.~~ e. of this Policy; and

3. No sooner than July 1, 2023: Children and youth with eligible conditions as described in Section III.A.1.g. of this Policy.

B. CalOptima or a Health Network shall proactively identify Members who may benefit from ECM and who meet criteria for at least one (1) of the Populations of Focus described in Section III.A. of this Policy, and who are not excluded from participation as described in Section III.A.2. of this Policy.

C. An ECM Provider shall conduct outreach and engagement activities for Medi-Cal-only Members who meet criteria for one (1) of the Populations of Focus as described in Sections II.J. and III.A. of this Policy.

D. CalOptima shall transition the Health Homes Program (HHP) and Whole Person Care (WPC) to ECM upon the DHCS-approved transition date.

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1. CalOptima or a Health Network shall automatically authorize the following Members for ECM services:

    a. All Members enrolled or in the process of being enrolled in HHP.

    b. All Members enrolled in WPC who are identified by the County of Orange as belonging to an ECM Population of Focus.

~~3.~~2. Within six (6) months of the DHCS-approved transition date, ~~CalOptima or a Health Network~~ECM Provider shall complete a reassessment of the Members who are automatically authorized for ECM under this section to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

E. CalOptima or a Health Network shall accept requests for ECM for a Member from the following types of Providers.

1. ECM Providers;

2. Other Providers in CalOptima's contracted network;

3. Community-based entities, including those contracted to provide Community Supports; and

4. Other Providers who serve potential ECM Members.

F. CalOptima or a Health Network shall allow a Member and/or a family member, guardian, Authorized Representative, caregiver, a Member's authorized support person, and/or external entity to request ECM on the Member's behalf and shall accept referrals as provided in Section III.E. of this Policy.

G. CalOptima or a Health Network shall make authorization determinations upon the basis of a Member's need for intense comprehensive care coordination, their ability to benefit from ECM, and the Member's agreement to receive such services.

H. CalOptima shall process a request for ECM in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

I. CalOptima shall provide notification of an ECM authorization decision to the requesting Provider and Member in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

J. ECM Providers shall provide ECM to Medi-Cal-only Members who meet eligibility criteria, who agree to participate and are authorized for these services.

1. Members with Original Medicare, a Medicare Advantage Plan or a Dual-Eligible Special Needs Plan shall be authorized for ECM if they are referred, meet criteria for (1) one or more of the Populations of Focus and agree to participate.

K. Members receiving ECM may request to change their ECM Provider at any time by notifying CalOptima or a Health Network by phone, in person or by electronic means, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

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1. CalOptima shall implement a requested ECM Provider change within thirty (30) calendar days.

2. Notwithstanding the above, a Member who is authorized for ECM pursuant to the eligibility criteria set forth in Section III.A.1.c. of this Policy may choose to select or deselect the County of Orange as their ECM Provider at any time by contacting CalOptima or their assigned Health Network and the change shall be implemented within thirty (30) calendar days.

III. PROCEDURE

A. ECM Eligibility

1. To be eligible for ECM, a CalOptima Member must meet the following eligibility criteria and not be excluded per the criteria in Section III.A.2.:

   a. Adults and children/youth experiencing Homelessness, that:

      i. Have at least one (1) complex physical, behavioral, or developmental health need; and

      ii. Are unable to successfully manage their health; and

      iii. Coordination of services would likely improve the Member's health outcomes and/or decrease the amount of high-cost services being utilized.

   b. Adult high utilizers, including Members experiencing one (1) or more of the following within a six (6)-month period, and which could be avoided with appropriate outpatient care and/or improved treatment adherence:

      i. Five (5) or more emergency room visits; or

      ii. Three (3) or more unplanned hospital admissions; or

      iii. Three (3) or more short-term, skilled nursing facility stays.

   c. Adults that meet the eligibility criteria for participation in or obtaining services through Orange County Specialty Mental Health System and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal program, who are actively experiencing at least one (1) complex social factor influencing their health and who meet one (1) or more of the following criteria:

      i. Are at high risk for institutionalization, overdose, and/or suicide; or

      ii. Use crisis services, emergency rooms, urgent care, or inpatient hospital stays as the sole source of care; or

      iii. Have experienced two (2) or more emergency department visits or two (2) or more hospitalizations within the past twelve (12) months because of an SMI or SUD within the past twelve (12) months; or

      iv. Are pregnant or post-partum women (12 months from delivery).

   d. Adults eligible for Long Term Care (LTC) and who are at risk for institutionalization, and:

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i. Without services and supports would require care for ninety (90) consecutive days or more in an inpatient nursing facility; and

ii. Are able to live safely in the community with wraparound supports.

e. Adult nursing facility residents who:

i. Want to transition back to the community; and

ii. Are strong candidates for a successful transition.

f. Adults and children/youth who are transitioning from incarceration or transitioned from incarceration within the past twelve (12) months, and who have at least one of the following conditions:

i. Chronic mental illness;

ii. SUD;

iii. Chronic disease (e.g., hepatitis C, diabetes);

iv. Intellectual or developmental disability;

v. Traumatic brain injury;

vi. HIV; or

vii. Pregnancy.

g. All other children and youth who have/are:

i. High utilizers; or

ii. Serious Emotional Disturbance (SED) or are identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis; or

iii. Enrolled in California Children's Services (CCS)/Whole Child Model (WCM) program with additional needs beyond those related to the CCS qualifying condition; or

iv. Involved in, or with a history of, involvement in child welfare services (including foster care up to age 26).

2. A Member shall not be eligible for ECM while enrolled in the following programs:

a. 1915(c) waivers, including the Multipurpose Senior Services Program (MSSP), Assisted Living Waiver (ALW), Home and Community-Based Alternatives (HCBA) Waiver, HIV/AIDS Waiver, Home and Community-Based (HCBS) Waiver for Individuals with Developmental Disabilities (DD), and the Self-Determination Program for Individuals with I/DD;

b. Fully integrated programs for Members dually eligible for Medicare and Medi-Cal including Cal MediConnect program, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and Program for All-Inclusive Care for the Elderly (PACE);

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c. Basic or complex case management programs;

d. Hospice;

e. California Community Transitions (CCT) Money Follows the Person (MFTP); and

f. Family Mosaic Project Services.

3. The following CalOptima dually-eligible Members may receive ECM if they meet Population of Focus criteria, agree to participate and services are not-duplicated between programs:

a. Members enrolled in OneCare;

b. Members enrolled in a Dual Eligible Special Needs Plan (D-SNP) look-alike;

c. Members enrolled in a D-SNP (currently unaligned);

d. Members enrolled in other Medicare Advantage Plans; or

e. Medicare Fee For Service (FFS).

4. CalOptima Members enrolled in the following programs may also be enrolled in ECM, if services are not duplicated:

a. County-based Targeted Case Management (TCM);

b. Specialty Mental Health (SMHS) TCM;

c. SMHS Intensive Care Coordination (ICC) for children;

d. DMC-ODS;

e. California Children's Services (CCS)/Whole Child Model (WCM);

f. Genetically Handicapped Person's Program (GHPP);

g. Community Based Adult Services (CBAS); and

h. AIDS Healthcare Foundation Plans.

B. WPC and HHP Transition

1. No later than one (1) month prior to January 1, 2022 or the ECM implementation date approved by DHCS, CalOptima shall provide a list of all WPC Members identified by Orange County on the Member Transition List (MTL) to each of the CalOptima contracted ECM Providers via secure FTP.

2. On or before January 1, 2022 or the ECM implementation date approved by DHCS, CalOptima or a Health Network shall ensure authorization is provided for all Members receiving ECM or Community Supports per the MTL to avoid disruption of services.

3. On or before January 1, 2022 or the ECM implementation date approved by DHCS, CalOptima or a Health Network shall ensure that all Members enrolled in or in the process of being enrolled in HHP have an ECM authorization in place to avoid disruption of services.

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4. The ECM Provider shall outreach to all transitioning Members and initiate ECM services, continuing attempts until the Member is reached or until at least three (3) attempts have been completed.

C. Non-Transitioning Members – Identification of ECM Eligibility

1. CalOptima shall consider the following when identifying non-transitioning Members that may benefit from ECM:

   a. Healthcare utilization;

   b. Physical, behavioral, developmental, and oral health care needs and risks, including those due to Social Determinants of Health; and

   c. Long-Term Services and Supports (LTSS) needs.

2. On a monthly basis, CalOptima shall also use the following stored Member data, as available, to identify Members appropriate for ECM:

   a. Enrollment data;

   b. Claims/encounter data;

   c. Utilization data;

   d. Pharmacy data;

   e. Laboratory results data;

   f. Assessment data;

   g. Members' Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA);

   h. Health Information Form (HIF)/Member Evaluation Tool (MET);

   i. Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD);

   j. Clinical information on physical/behavioral health;

   k. SMI/SUD data, as available;

   l. WCM risk stratification information;

   m. Information about Social Determinants of Health, including standardized assessment tools and/or ICD-10 codes;

   n. Results from any Adverse Childhood Experiences (ACEs) screening; and

   o. Other available cross-sector data and information, including housing, social services, foster care, criminal justice history and other information relevant to the ECM Populations of Focus.

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3. CalOptima shall identify Members eligible for the Homeless Population of Focus as follows:

    a. Presence of a Z590 ICD-10 code on any claim in the last fifteen (15) months (12 months + 3 months for run-out); or

    b. An address on file suggesting non-permanent or unconventional living arrangements; and

    c. The presence of one (1) or more conditions indicating a complex physical, behavioral, or developmental health need. This shall be defined as one (1) or more claims that include one (1) or more ICD-10 code(s) designated as potentially complex in the last fifteen (15) months (12 months + 3 months for run-out).

    d. The inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

4. CalOptima shall identify Members eligible in the high utilizer Population of Focus through claims or encounter data as follows:

    a. Five (5) or more emergency room visits within a rolling six (6) month period, based on the presence of emergency room charges on a hospital outpatient bill type that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or

    b. Three (3) or more unplanned acute hospital inpatient admissions within a rolling six (6) month period, based on either having emergency room charges and/or an admit type other than "elective" or "newborn" that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or

    c. Three (3) or more skilled nursing facility stays within a rolling six (6) month period, based on a UB04 bill type indicating the Provider is a skilled nursing facility billing for other than Long Term Care that could have been avoided with appropriate outpatient care or improved treatment adherence.

5. CalOptima shall identify Members eligible in the SMI and/or SUD Population of Focus who meet three (3) categories of criteria evidenced by a claim or Encounter that includes:

    a. Adults meeting the eligibility criteria for participation in or obtaining services through the county Specialty Mental Health System (SMS) and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) Program, identified as having: one (1) or more ICD-10 codes indicating potential SMI or SUD within the last fifteen (15) months; and

    b. An ICD-10 code for one (1) or more Social Determinants of Health and/or a positive Adverse Childhood Event HCPCS code in the last fifteen (15) months, and one (1) or more of the following:

        i. Delivery of a child(ren) in the past twelve (12) months; or

        ii. An ICD-10 code for pregnancy without a claim or encounter for delivery or termination of the pregnancy subsequent to the pregnancy diagnosis; or

        iii. An ICD-10 code for narcotics poisoning or risk for suicide; or

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iv. An emergency room visit or unplanned acute hospital admission, as described in Section III.C.4. of this Policy, that do not have a claim for physician evaluation and management outside a facility setting.

6. CalOptima shall produce a monthly report identifying Members that meet criteria for a Population of Focus.

a. CalOptima shall provide the list of potential ECM-eligible Members to the assigned ECM Providers via secure FTP site.

D. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) who were previously identified and receiving ECM, CalOptima or Health Network shall:

1. Authorize the Member for ECM upon :

a. A direct request from the Member, the Member's family, or authorized representative along with an attestation from the Member.

b. Review of Encounter data demonstrating ECM utilization in previous ninety (90) days.

2. Ensure timely outreach and engagement with the Member and engage with the Member's previous MCP, the Member, or ECM provider, as appropriate, to mitigate gaps in care.

3. Reassess the Member based on discontinuation criteria in accordance with CalOptima Policy GG.1353: Enhanced Care Management Service Delivery.

~~D.~~E. Outreach and Engagement

1. ECM Providers shall outreach to Members meeting criteria for a defined Population of Focus as follows:

a. The ECM Provider shall initiate outreach promptly for a Member authorized for ECM services, prioritizing those with the most immediate needs.

i. Members with urgent needs may be identified at the time of referral.

b. The ECM Provider shall outreach to a Member to engage them in ECM services until the Member is reached or at least three (3) attempts have been completed.

i. Member engagement shall be performed primarily through in-person contact, according to Member preference and the needs of each Population of Focus.

a) ECM Providers shall focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate, with the Member's consent, and in compliance with CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services and APL 19-009 (Revised): Telehealth Services Policy, including subsequent revisions of the APL.

ii. If in-person engagement is not available or appropriate, an ECM Provider shall engage an ECM Member via telephonic, mail, or other written communication.

2. Outreach activities to Members in the Homeless Population of Focus may include, but are not limited to:

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a. In-person, telephonic or video communication at local homeless shelters, navigation centers and hot spots where Homeless Members may spend time;

b. In-person telephonic or video communication at Recuperative Care facilities;

c. Coordination between CalOptima's Homeless Response Team and Clinical Field Teams acting as ECM ambassadors to the Homeless Members they serve; and

d. Collaboration with community clinics, Providers and other community-based organizations who care for many Members experiencing Homelessness.

3. Outreach to Members in the high-utilizer Population of Focus may include, but is not limited to:

a. In-person, telephonic or video communication, as appropriate, during a hospital or nursing home stay, or as part of the discharge planning process;

b. In-person, telephonic or video communication, as appropriate, following an emergency room visit;

c. Collaboration with contracted hospital staff serving Members with high utilization of the emergency room and inpatient hospital services; and

d. Education regarding ECM services and offer of services by CalOptima or Health Network staff in the usual course of communication with Members.

4. Outreach to Members in the SMI/SUD Population of Focus may include, but is not limited to:

a. In-person, telephonic or video communication, as possible, during a hospital stay or as part of the discharge planning process, or following an emergency room visit; and

b. Collaboration with County Specialty Mental Health staff, Drug Medi-Cal Providers, and hospital Providers.

5. A Member may accept or decline ECM services. The ECM Provider shall honor the Member's decision, document it in their system of record and proceed appropriately.

6. A Member may receive services from more than one ECM Provider if the services provided are complementary, not duplicative.

E. CalOptima shall accept referrals by facsimile, email or other electronic means.

1. CalOptima shall make an ECM Referral form available on CalOptima's website (~~www.caloptima.org).~~https://www.caloptima.org/).

2. CalOptima or a Health Network shall review ECM referral requests to confirm Member eligibility for services against the Population of Focus criteria described in Sections III.C. of this Policy.

3. CalOptima and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

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4. Upon approval of a request for authorization, the ECM Provider will call the Member to notify them of the authorization and to initiate services.

IV. ATTACHMENT(S)

~~A. CalAIM Enhanced Care Management (ECM) Referral Form~~

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and ~~In Lieu of Services (ILOS)~~Community Supports Model of Care Template
B. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
C. Department of Health Care Services (DHCS) Managed Care Plan ECM and ILOS Contract Template
D. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management Policy Guide
E. Department of Health Care Services (DHCS) Medi-Cal 2020 Waiver, Attachment X
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy GG.1353: Enhanced Care Management Service Delivery
H. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services
K. CalOptima Policy GG.1900: Behavioral Services
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009 (Revised): Telehealth Services Policy
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-012: Enhanced Care Management Requirements

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	Regulatory Agency	Response
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1354	Enhanced Care Management - Eligibility and Outreach	Medi-Cal
Revised	TBD	GG.1354	Enhanced Care Management - Eligibility and Outreach	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Childhood Experiences (ACEs)	Potentially traumatic events in a child's life occurring before the age of 18 that can have negative and lasting effects on health and well-being.
Authorized Representative	A designated by the Member or 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) Program	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 (2l) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), 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.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A contracted Provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and expertise providing one (1) or more of the Community Supports approved by the DHCS.
Drug Medi-Cal (DMC) or Drug Medi-Cal-Organized Delivery System (DMC-ODS)	A pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorder (SUD). The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in substance abuse treatment, and coordinates with other systems of care. In Orange County, the Orange County Health Care Agency operates the DMC-ODS.

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Term	Definition
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	Providers within the community that have a contractual relationship with CalOptima (such as delegated Health Networks ~~and the County of Orange) or CalOptima acting directly (COD).~~)\to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
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.
Homeless or Homelessness	Members experiencing homelessness include the following: 1. An individual or family who lacks adequate nighttime residence; 2. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation; 3. An individual or family living in a shelter; 4. An individual exiting an institution into homelessness; 5. An individual or family who will imminently lose housing in the next 30 days; 6. An unaccompanied youth, and homeless families and children and youth defined as homeless under other federal statutes; or 7. Individuals fleeing domestic violence.
ICD-10	The set of diagnosis codes used in the healthcare industry to define a patient's disease state or health status.
Long Term Care	Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS) 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.

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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.
Populations of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers; c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and f. Transitioning from incarceration.
Practitioner	A licensed independent Practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

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Term	Definition
Serious Emotional Disturbance (SED)	Persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.
Serious Mental Illness (SMI)	Persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Major life activities include activities of daily living (e.g., eating, bathing, dressing), instrumental activities of daily living (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication), and functioning in social, family, and vocational/educational contexts.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.
Specialty Mental Health (SMH) Services	Rehabilitation services, which include 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. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services.

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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.

1

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Policy:	GG.1354
Title:	**Enhanced Care Management - Eligibility and Outreach**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 2022030 BOD Review Only

I. PURPOSE

This policy describes the implementation of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative, including the processes to identify eligible Members and conduct outreach activities.

II. POLICY

A. CalOptima shall implement ECM in three (3) phases for Populations of Focus, as prescribed by the Department of Health Care Services (DHCS):

1. No sooner than January 1, 2022: For Members experiencing Homelessness (adults and children/youth), adult high utilizers, and adults with Serious Mental Illness (SMI) or Substance Use Disorder (SUD) and Members transitioning from incarceration (adults and children/youth) as described in Sections III.A.1.a.-c, and f. of this Policy;

2. No sooner than January 1, 2023: For Members eligible for Long Term Care (LTC) and who are at risk for institutionalization and nursing facility residents transitioning to the community, as described in Section III.A.1.d-e. of this Policy; and

3. No sooner than July 1, 2023: Children and youth with eligible conditions as described in Section III.A.1.g. of this Policy.

B. CalOptima or a Health Network shall proactively identify Members who may benefit from ECM and who meet criteria for at least one (1) of the Populations of Focus described in Section III.A. of this Policy, and who are not excluded from participation as described in Section III.A.2. of this Policy.

C. An ECM Provider shall conduct outreach and engagement activities for Medi-Cal-only Members who meet criteria for one (1) of the Populations of Focus as described in Sections II.J. and III.A. of this Policy.

D. CalOptima shall transition the Health Homes Program (HHP) and Whole Person Care (WPC) to ECM upon the DHCS-approved transition date.

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1. CalOptima or a Health Network shall automatically authorize the following Members for ECM services:

    a. All Members enrolled or in the process of being enrolled in HHP.

    b. All Members enrolled in WPC who are identified by the County of Orange as belonging to an ECM Population of Focus.

2. Within six (6) months of the DHCS-approved transition date, ECM Provider shall complete a reassessment of the Members who are automatically authorized for ECM under this section to confirm whether ECM or a lower level of care coordination best meets the Member's needs.

E. CalOptima or a Health Network shall accept requests for ECM for a Member from the following types of Providers.

1. ECM Providers;

2. Other Providers in CalOptima's contracted network;

3. Community-based entities, including those contracted to provide Community Supports; and

4. Other Providers who serve potential ECM Members.

F. CalOptima or a Health Network shall allow a Member and/or a family member, guardian, Authorized Representative, caregiver, a Member's authorized support person, and/or external entity to request ECM on the Member's behalf and shall accept referrals as provided in Section III.E. of this Policy.

G. CalOptima or a Health Network shall make authorization determinations upon the basis of a Member's need for intense comprehensive care coordination, their ability to benefit from ECM, and the Member's agreement to receive such services.

H. CalOptima shall process a request for ECM in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

I. CalOptima shall provide notification of an ECM authorization decision to the requesting Provider and Member in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

J. ECM Providers shall provide ECM to Medi-Cal-only Members who meet eligibility criteria, who agree to participate and are authorized for these services.

1. Members with Original Medicare, a Medicare Advantage Plan or a Dual-Eligible Special Needs Plan shall be authorized for ECM if they are referred, meet criteria for (1) one or more of the Populations of Focus and agree to participate.

K. Members receiving ECM may request to change their ECM Provider at any time by notifying CalOptima or a Health Network by phone, in person or by electronic means, in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process.

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1. CalOptima shall implement a requested ECM Provider change within thirty (30) calendar days.

2. Notwithstanding the above, a Member who is authorized for ECM pursuant to the eligibility criteria set forth in Section III.A.1.c. of this Policy may choose to select or deselect the County of Orange as their ECM Provider at any time by contacting CalOptima or their assigned Health Network and the change shall be implemented within thirty (30) calendar days.

III. PROCEDURE

A. ECM Eligibility

1. To be eligible for ECM, a CalOptima Member must meet the following eligibility criteria and not be excluded per the criteria in Section III.A.2.:

   a. Adults and children/youth experiencing Homelessness, that:

      i. Have at least one (1) complex physical, behavioral, or developmental health need; and

      ii. Are unable to successfully manage their health; and

      iii. Coordination of services would likely improve the Member's health outcomes and/or decrease the amount of high-cost services being utilized.

   b. Adult high utilizers, including Members experiencing one (1) or more of the following within a six (6)-month period, and which could be avoided with appropriate outpatient care and/or improved treatment adherence:

      i. Five (5) or more emergency room visits; or

      ii. Three (3) or more unplanned hospital admissions; or

      iii. Three (3) or more short-term, skilled nursing facility stays.

   c. Adults that meet the eligibility criteria for participation in or obtaining services through Orange County Specialty Mental Health System and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal program, who are actively experiencing at least one (1) complex social factor influencing their health and who meet one (1) or more of the following criteria:

      i. Are at high risk for institutionalization, overdose, and/or suicide; or

      ii. Use crisis services, emergency rooms, urgent care, or inpatient hospital stays as the sole source of care; or

      iii. Have experienced two (2) or more emergency department visits or two (2) or more hospitalizations within the past twelve (12) months because of an SMI or SUD within the past twelve (12) months; or

      iv. Are pregnant or post-partum women (12 months from delivery).

   d. Adults eligible for Long Term Care (LTC) and who are at risk for institutionalization, and:

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i. Without services and supports would require care for ninety (90) consecutive days or more in an inpatient nursing facility; and

ii. Are able to live safely in the community with wraparound supports.

e. Adult nursing facility residents who:

i. Want to transition back to the community; and

ii. Are strong candidates for a successful transition.

f. Adults and children/youth who are transitioning from incarceration or transitioned from incarceration within the past twelve (12) months, and who have at least one of the following conditions:

i. Chronic mental illness;

ii. SUD;

iii. Chronic disease (e.g., hepatitis C, diabetes);

iv. Intellectual or developmental disability;

v. Traumatic brain injury;

vi. HIV; or

vii. Pregnancy.

g. All other children and youth who have/are:

i. High utilizers; or

ii. Serious Emotional Disturbance (SED) or are identified to be at clinical high risk for psychosis or experiencing a first episode of psychosis; or

iii. Enrolled in California Children's Services (CCS)/Whole Child Model (WCM) program with additional needs beyond those related to the CCS qualifying condition; or

iv. Involved in, or with a history of, involvement in child welfare services (including foster care up to age 26).

2. A Member shall not be eligible for ECM while enrolled in the following programs:

a. 1915(c) waivers, including the Multipurpose Senior Services Program (MSSP), Assisted Living Waiver (ALW), Home and Community-Based Alternatives (HCBA) Waiver, HIV/AIDS Waiver, Home and Community-Based (HCBS) Waiver for Individuals with Developmental Disabilities (DD), and the Self-Determination Program for Individuals with I/DD;

b. Fully integrated programs for Members dually eligible for Medicare and Medi-Cal including Cal MediConnect program, Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), and Program for All-Inclusive Care for the Elderly (PACE);

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c. Basic or complex case management programs;

d. Hospice;

e. California Community Transitions (CCT) Money Follows the Person (MFTP); and

f. Family Mosaic Project Services.

3. The following CalOptima dually-eligible Members may receive ECM if they meet Population of Focus criteria, agree to participate and services are not-duplicated between programs:

a. Members enrolled in OneCare;

b. Members enrolled in a Dual Eligible Special Needs Plan (D-SNP) look-alike;

c. Members enrolled in a D-SNP (currently unaligned);

d. Members enrolled in other Medicare Advantage Plans; or

e. Medicare Fee For Service (FFS).

4. CalOptima Members enrolled in the following programs may also be enrolled in ECM, if services are not duplicated:

a. County-based Targeted Case Management (TCM);

b. Specialty Mental Health (SMHS) TCM;

c. SMHS Intensive Care Coordination (ICC) for children;

d. DMC-ODS;

e. California Children's Services (CCS)/Whole Child Model (WCM);

f. Genetically Handicapped Person's Program (GHPP);

g. Community Based Adult Services (CBAS); and

h. AIDS Healthcare Foundation Plans.

B. WPC and HHP Transition

1. No later than one (1) month prior to January 1, 2022 or the ECM implementation date approved by DHCS, CalOptima shall provide a list of all WPC Members identified by Orange County on the Member Transition List (MTL) to each of the CalOptima contracted ECM Providers via secure FTP.

2. On or before January 1, 2022 or the ECM implementation date approved by DHCS, CalOptima or a Health Network shall ensure authorization is provided for all Members receiving ECM or Community Supports per the MTL to avoid disruption of services.

3. On or before January 1, 2022 or the ECM implementation date approved by DHCS, CalOptima or a Health Network shall ensure that all Members enrolled in or in the process of being enrolled in HHP have an ECM authorization in place to avoid disruption of services.

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4. The ECM Provider shall outreach to all transitioning Members and initiate ECM services, continuing attempts until the Member is reached or until at least three (3) attempts have been completed.

C. Non-Transitioning Members – Identification of ECM Eligibility

1. CalOptima shall consider the following when identifying non-transitioning Members that may benefit from ECM:

   a. Healthcare utilization;

   b. Physical, behavioral, developmental, and oral health care needs and risks, including those due to Social Determinants of Health; and

   c. Long-Term Services and Supports (LTSS) needs.

2. On a monthly basis, CalOptima shall also use the following stored Member data, as available, to identify Members appropriate for ECM:

   a. Enrollment data;

   b. Claims/encounter data;

   c. Utilization data;

   d. Pharmacy data;

   e. Laboratory results data;

   f. Assessment data;

   g. Members' Staying Healthy Assessment (SHA)/Individual Health Education Behavioral Assessment (IHEBA);

   h. Health Information Form (HIF)/Member Evaluation Tool (MET);

   i. Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD);

   j. Clinical information on physical/behavioral health;

   k. SMI/SUD data, as available;

   l. WCM risk stratification information;

   m. Information about Social Determinants of Health, including standardized assessment tools and/or ICD-10 codes;

   n. Results from any Adverse Childhood Experiences (ACEs) screening; and

   o. Other available cross-sector data and information, including housing, social services, foster care, criminal justice history and other information relevant to the ECM Populations of Focus.

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3. CalOptima shall identify Members eligible for the Homeless Population of Focus as follows:

    a. Presence of a Z590 ICD-10 code on any claim in the last fifteen (15) months (12 months + 3 months for run-out); or

    b. An address on file suggesting non-permanent or unconventional living arrangements; and

    c. The presence of one (1) or more conditions indicating a complex physical, behavioral, or developmental health need. This shall be defined as one (1) or more claims that include one (1) or more ICD-10 code(s) designated as potentially complex in the last fifteen (15) months (12 months + 3 months for run-out).

    d. The inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes and/or decreased utilization of high-cost services.

4. CalOptima shall identify Members eligible in the high utilizer Population of Focus through claims or encounter data as follows:

    a. Five (5) or more emergency room visits within a rolling six (6) month period, based on the presence of emergency room charges on a hospital outpatient bill type that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or

    b. Three (3) or more unplanned acute hospital inpatient admissions within a rolling six (6) month period, based on either having emergency room charges and/or an admit type other than “elective” or “newborn” that could have been avoided with appropriate outpatient care or improved treatment adherence; and/or

    c. Three (3) or more skilled nursing facility stays within a rolling six (6) month period, based on a UB04 bill type indicating the Provider is a skilled nursing facility billing for other than Long Term Care that could have been avoided with appropriate outpatient care or improved treatment adherence.

5. CalOptima shall identify Members eligible in the SMI and/or SUD Population of Focus who meet three (3) categories of criteria evidenced by a claim or Encounter that includes:

    a. Adults meeting the eligibility criteria for participation in or obtaining services through the county Specialty Mental Health System (SMS) and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) Program, identified as having: one (1) or more ICD-10 codes indicating potential SMI or SUD within the last fifteen (15) months; and

    b. An ICD-10 code for one (1) or more Social Determinants of Health and/or a positive Adverse Childhood Event HCPCS code in the last fifteen (15) months, and one (1) or more of the following:

        i. Delivery of a child(ren) in the past twelve (12) months; or

        ii. An ICD-10 code for pregnancy without a claim or encounter for delivery or termination of the pregnancy subsequent to the pregnancy diagnosis; or

        iii. An ICD-10 code for narcotics poisoning or risk for suicide; or

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iv. An emergency room visit or unplanned acute hospital admission, as described in Section III.C.4. of this Policy, that do not have a claim for physician evaluation and management outside a facility setting.

6. CalOptima shall produce a monthly report identifying Members that meet criteria for a Population of Focus.

   a. CalOptima shall provide the list of potential ECM-eligible Members to the assigned ECM Providers via secure FTP site.

D. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) who were previously identified and receiving ECM, CalOptima or Health Network shall:

1. Authorize the Member for ECM upon :

   a. A direct request from the Member, the Member's family, or authorized representative along with an attestation from the Member.

   b. Review of Encounter data demonstrating ECM utilization in previous ninety (90) days.

2. Ensure timely outreach and engagement with the Member and engage with the Member's previous MCP, the Member, or ECM provider, as appropriate, to mitigate gaps in care.

3. Reassess the Member based on discontinuation criteria in accordance with CalOptima Policy GG.1353: Enhanced Care Management Service Delivery.

E. Outreach and Engagement

1. ECM Providers shall outreach to Members meeting criteria for a defined Population of Focus as follows:

   a. The ECM Provider shall initiate outreach promptly for a Member authorized for ECM services, prioritizing those with the most immediate needs.

      i. Members with urgent needs may be identified at the time of referral.

   b. The ECM Provider shall outreach to a Member to engage them in ECM services until the Member is reached or at least three (3) attempts have been completed.

      i. Member engagement shall be performed primarily through in-person contact, according to Member preference and the needs of each Population of Focus.

         a) ECM Providers shall focus on building relationships with Members, and in-person visits may be supplemented with secure teleconferencing and telehealth, when appropriate, with the Member's consent, and in compliance with CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services and APL 19-009 (Revised): Telehealth Services Policy, including subsequent revisions of the APL.

      ii. If in-person engagement is not available or appropriate, an ECM Provider shall engage an ECM Member via telephonic, mail, or other written communication.

2. Outreach activities to Members in the Homeless Population of Focus may include, but are not limited to:

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a. In-person, telephonic or video communication at local homeless shelters, navigation centers and hot spots where Homeless Members may spend time;

b. In-person telephonic or video communication at Recuperative Care facilities;

c. Coordination between CalOptima's Homeless Response Team and Clinical Field Teams acting as ECM ambassadors to the Homeless Members they serve; and

d. Collaboration with community clinics, Providers and other community-based organizations who care for many Members experiencing Homelessness.

3. Outreach to Members in the high-utilizer Population of Focus may include, but is not limited to:

a. In-person, telephonic or video communication, as appropriate, during a hospital or nursing home stay, or as part of the discharge planning process;

b. In-person, telephonic or video communication, as appropriate, following an emergency room visit;

c. Collaboration with contracted hospital staff serving Members with high utilization of the emergency room and inpatient hospital services; and

d. Education regarding ECM services and offer of services by CalOptima or Health Network staff in the usual course of communication with Members.

4. Outreach to Members in the SMI/SUD Population of Focus may include, but is not limited to:

a. In-person, telephonic or video communication, as possible, during a hospital stay or as part of the discharge planning process, or following an emergency room visit; and

b. Collaboration with County Specialty Mental Health staff, Drug Medi-Cal Providers, and hospital Providers.

5. A Member may accept or decline ECM services. The ECM Provider shall honor the Member's decision, document it in their system of record and proceed appropriately.

6. A Member may receive services from more than one ECM Provider if the services provided are complementary, not duplicative.

E. CalOptima shall accept referrals by facsimile, email or other electronic means.

1. CalOptima shall make an ECM Referral form available on CalOptima's website (https://www.caloptima.org/).

2. CalOptima or a Health Network shall review ECM referral requests to confirm Member eligibility for services against the Population of Focus criteria described in Sections III.C. of this Policy.

3. CalOptima and its Health Networks shall notify the requesting Practitioner or Provider and/or Member or Member's Authorized Representative, as appropriate, regarding any decision to deny, approve, modify, or delay an authorization request in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

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4. Upon approval of a request for authorization, the ECM Provider will call the Member to notify them of the authorization and to initiate services.

IV. ATTACHMENT(S)

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and Community Supports Model of Care Template
B. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
C. Department of Health Care Services (DHCS) Managed Care Plan ECM and ILOS Contract Template
D. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management Policy Guide
E. Department of Health Care Services (DHCS) Medi-Cal 2020 Waiver, Attachment X
F. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
G. CalOptima Policy GG.1353: Enhanced Care Management Service Delivery
H. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization
I. CalOptima Policy GG.1508: Authorization and Processing of Referrals
J. CalOptima Policy GG.1665: Telehealth and Other Technology-Enabled Services
K. CalOptima Policy GG.1900: Behavioral Services
L. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-009 (Revised): Telehealth Services Policy
M. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-012: Enhanced Care Management Requirements

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1354	Enhanced Care Management - Eligibility and Outreach	Medi-Cal
Revised	TBD	GG.1354	Enhanced Care Management - Eligibility and Outreach	Medi-Cal

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IX. GLOSSARY

Term	Definition
Adverse Childhood Experiences (ACEs)	Potentially traumatic events in a child's life occurring before the age of 18 that can have negative and lasting effects on health and well-being.
Authorized Representative	A designated by the Member or 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) Program	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 (2l) years who have CCS-eligible conditions, as defined in Title 22, California Code of Regulations (CCR), 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.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A contracted Provider of DHCS-approved Community Supports. Community Supports Providers are entities with experience and expertise providing one (1) or more of the Community Supports approved by the DHCS.
Drug Medi-Cal (DMC) or Drug Medi-Cal-Organized Delivery System (DMC-ODS)	A pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with substance use disorder (SUD). The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. Critical elements of the DMC-ODS Pilot include providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence-based practices in substance abuse treatment, and coordinates with other systems of care. In Orange County, the Orange County Health Care Agency operates the DMC-ODS.

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Term	Definition
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	Providers within the community that have a contractual relationship with CalOptima (such as delegated Health Networks) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
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.
Homeless or Homelessness	Members experiencing homelessness include the following: 1. An individual or family who lacks adequate nighttime residence; 2. An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation; 3. An individual or family living in a shelter; 4. An individual exiting an institution into homelessness; 5. An individual or family who will imminently lose housing in the next 30 days; 6. An unaccompanied youth, and homeless families and children and youth defined as homeless under other federal statutes; or 7. Individuals fleeing domestic violence.
ICD-10	The set of diagnosis codes used in the healthcare industry to define a patient's disease state or health status.
Long Term Care	Care provided in a skilled nursing facility and sub-acute care services that lasts longer than 60 days.
Long Term Services and Supports (LTSS)	A wide variety of services and supports that help Members meet their daily needs for assistance and improve the quality of their lives. LTSS are provided over an extended period, predominantly in homes and communities, but also in facility-based settings such as nursing facilities. As described in Welfare and Institutions Code section 14186.1, Medi-Cal covered LTSS includes all the following: 1. Community-Based Adult Services (CBAS); 2. In-Home Supportive Services (IHSS) 3. Multipurpose Senior Services Program (MSSP) services; and 4. Skilled nursing facility services and subacute care services.

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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.
Populations of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers; c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and f. Transitioning from incarceration.
Practitioner	A licensed independent Practitioner including but not limited to a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), Speech and Language Therapist furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.

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Term	Definition
Serious Emotional Disturbance (SED)	Persons from birth up to age 18, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally-appropriate social, behavioral, cognitive, communicative, or adaptive skills.
Serious Mental Illness (SMI)	Persons, age 18 and over, who currently, or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities. Major life activities include activities of daily living (e.g., eating, bathing, dressing), instrumental activities of daily living (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication), and functioning in social, family, and vocational/educational contexts.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.
Specialty Mental Health (SMH) Services	Rehabilitation services, which include 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. Specialty Mental Health Services may also include: 1. Psychiatric Inpatient Hospital Services; 2. Targeted Case Management; 3. Psychiatrist services; 4. Psychologist services; 5. Early Periodic Screening, Detection, and Treatment (EPSDT) supplemental Specialty Mental Health Services; and/or 6. Psychiatric nursing facility services.

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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.

1

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Policy:	GG.1355
Title:	**Community Supports**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy describes the eligibility criteria for CalOptima Community Supports and identifies the requirements for the referral, authorization, and provision of CalOptima Community Supports under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

II. POLICY

A. Community Supports are medically appropriate, cost-effective alternatives provided as a substitute to services covered under the California Medicaid State Plan and are delivered by a different Provider or in a different setting than those described in the State Plan. These services shall not reduce or jeopardize Members' access to State Plan services.

B. Community Supports can only be covered if the State determines they are medically appropriate and cost-effective alternatives and are identified and authorized in CalOptima's Medi-Cal Contract with the Department of Health Care Services (DHCS).

C. A Member's participation in CalOptima Community Supports is optional; CalOptima shall not require a Member to use CalOptima Community Supports.

D. CalOptima shall ensure the underlying State Plan Covered Services are made available to the Member, if Medically Necessary for the Member, or if the Member declines CalOptima Community Supports.

E. CalOptima shall provide public notice of any limitations on Community Supports when an alternative approach involving narrowing eligible populations, including specifying such limitations in the Member Handbook/Evidence of Coverage and website, in addition to receiving written approval from DHCS.

~~E.~~F. To the extent a Member is receiving care or case management, CalOptima Community Supports should be integrated with care or case management, including Enhanced Care Management (ECM) when appropriate.

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~~F.~~G. CalOptima may delegate CalOptima Community Supports to Kaiser Foundation Health Plan (Kaiser), in accordance with the CalOptima Contract for Health Care Services and the Delegation Agreement.

~~G.~~H. Effective no sooner than January 1, 2022, CalOptima shall offer four (4) selected DHCS-approved CalOptima Community Supports, listed below and further defined in Attachment A of this Policy.

1. Housing Transition Navigation Services;
2. Housing Deposits;
3. Housing Tenancy and Sustaining Services; and
4. Recuperative Care (Medical Respite).

I. In the event that CalOptima ~~may offer additional~~ expands Community Supports ~~from the~~, the following services listed below may be considered and are further defined in Attachment A of this Policy.

1. Short-Term Post-Hospitalization Housing;
2. Medically-Tailored meals;
3. Sobering Centers;
4. Personal Care/Homemaker Services; and
5. Day Habilitation Program
6. Respite Services;
7. Nursing Facility Transition/Diversion to Assisted Living Facilities (Elderly and Adult Residential Facilities);
8. Community Transition Services/Nursing Facility Transition to a Home;
9. Environmental Accessibility Adaptions (Modifications); and
10. Asthma Remediation.

J. CalOptima will notify DHCS ~~approved list every~~ of any additional community support offering with six (6) ~~months upon~~months' notice and include submission of an updated CalAIM Model of Care to DHCS.

~~H.~~K. CalOptima shall provide CalOptima Community Supports training and technical assistance to Community Supports Providers, through in-person sessions, webinars, and/or telephone calls, as necessary and in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training and Section III.C. of this Policy.

~~I.~~L. A Community Supports Provider shall not receive payment from CalOptima for the provision of any CalOptima Community Supports not authorized by CalOptima or a Health Network.

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~~J.~~M. To be eligible for participation in CalOptima Community Supports, a Member must meet the DHCS-specific requirements for the CalOptima Community Supports under consideration, as described in Attachment B of this Policy.

O. CalOptima or a Health Network shall accept referrals for CalOptima Community Supports from Providers, other community-based entities, Members and/or family members.

P. CalOptima or the Health Network shall use systems and processes capable of tracking CalOptima Community Supports referrals, access to CalOptima Community Supports, and Grievances and Appeals.

1. CalOptima or the Health Network shall track CalOptima Community Supports referrals and will support Community Supports Provider access to systems and processes allowing them to track and manage referral and Member information.

Q. CalOptima shall regularly monitor and provide oversight of Community Supports Providers to ensure compliance with regulatory, contractual, and business requirements as described in Section III.M. of this Policy.

R. A Community Supports Provider or Member, as applicable, shall be entitled to Grievance and Appeals procedures in accordance with CalOptima Policies GG.1510: Appeal Process, HH.1101: CalOptima Provider Complaint, and HH.1102: Member Grievance.

S. CalOptima Community Supports are subject to the State Fair Hearings process, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. Informing Members and Providers

1. CalOptima shall inform Members and Providers about current and newly added CalOptima-offered Community Supports and the referral process, including how to submit the CalOptima Community Supports request through:

a. Member communication such as the Member Handbook, CalOptima website, Member Orientation meetings, and communication with CalOptima representatives (e.g., Customer Service staff, case managers); and

b. Provider communication including but not limited to the CalOptima website (www.caloptima.org), CalOptima Provider Manual, CalOptima Policies and Procedures, CalOptima Community Announcement, other educational materials, as well as through community events and other regularly scheduled CalOptima stakeholder forums.

2. CalOptima may discontinue a specific CalOptima Community Supports annually, with notice to DHCS, at the end of the calendar year, except in cases where the CalOptima Community Supports is terminated due to Member health, safety, or welfare concerns.

a. CalOptima shall ensure CalOptima Community Supports that were authorized for a Member prior to the discontinuation of that specific CalOptima Community Supports are not disrupted by a change in CalOptima Community Supports offerings, either by completing the authorized services or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.

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b. CalOptima shall publicize the service end date and provide at least ninety (90) calendar days' notice to Members. Notice to Members affected by a decision to discontinue a specific CalOptima Community Supports shall include:

i. The change and timing of discontinuation; and

ii. The procedures that will be used to ensure completion of the authorized CalOptima Community Supports or a transition into other Medically Necessary services.

c. CalOptima shall implement a plan for continuity of care for Members receiving the discontinued CalOptima Community Supports.

B. Provider Medi-Cal Enrollment and Credentialing or CalOptima's Vetting Process

1. If a State level enrollment pathway exists for the Community Supports Provider, CalOptima shall verify that the Community Supports Provider is enrolled in Medi-Cal, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima shall also credential the Community Supports Provider in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Assessment and Re-Assessment of Organizational Providers, as applicable.

2. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima shall verify the qualifications of the Provider or provider organization to ensure they meet the standards and capabilities to be a Community Supports Provider in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring. CalOptima shall also consider the following factors as part of CalOptima's process for vetting the qualifications and experience of Community Supports Providers:

a. Ability to receive referrals from CalOptima and Health Networks for the authorized CalOptima Community Supports service;

b. Sufficient experience to provide services similar to the specific CalOptima Community Supports they are contracted to provide within the service area;

c. Ability to submit claims or invoices for CalOptima Community Supports using standardized protocols;

d. Business licensing that meets industry standards;

e. Capability to comply with all reporting and oversight requirements;

f. History of fraud, waste, and/or abuse;

g. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

h. History of liability claims against the Community Supports Provider.

C. Provider Training

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1. In addition to network Provider training requirements described in CalOptima's Medi-Cal Contract with DHCS, CalOptima will provide the CalOptima Community Supports training described below to Community Supports Providers, including through in-person sessions, webinars, and/or calls, as necessary:

    a. CalOptima Community Supports program overview, Community Supports Provider role, community resources and referrals, as well as operational and topic-specific trainings.

    b. Special populations, Social Determinants of Health, trauma-informed care, health literacy, data-sharing and reporting requirements will also be covered.

D. Identifying Members and Receiving Requests for CalOptima Community Supports

1. CalOptima and the Health Networks shall identify Members who will benefit from one or more CalOptima Community Supports by:

    a. Working with ECM Providers to identify Members receiving ECM who could benefit from CalOptima Community Supports;

    b. Proactively identifying Members who may benefit from the CalOptima Community Supports through review of available data indicating a Member meets specific eligibility criteria, as described in Attachment B of this Policy;

    c. Accepting CalOptima Community Supports requests from Providers and other community-based entities; and

    d. Accepting CalOptima Community Supports requests from a Member, family member, guardian, caregiver, and/or authorized support person.

2. CalOptima shall refer Members to a Community Supports Provider within two (2) business days of issuing authorization for the service.

3. CalOptima shall provide Medically Necessary Covered Services regardless of whether the Member has been offered a Community Support, is currently receiving a Community Support, or has received a Community Support in the past.

~~3.~~4. If a Community Supports Provider capacity is limited, CalOptima or a Health Network shall prioritize the initiation of CalOptima Community Supports to Members who:

    a. Meet all CalOptima Community Supports criteria; and

    b. Demonstrate a high level of commitment to participating in services.

E. Authorization of CalOptima Community Supports is required prior to the initiation of services.

1. CalOptima shall ensure timely processing of expedited and routine CalOptima Community Supports authorization requests in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

    a. An authorization request for CalOptima Community Supports may be expedited when a specific, time-limited indication for the service requested exists and is a critical component of appropriate delivery of the CalOptima Community Supports.

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i. Recuperative Care Providers may issue a presumptive authorization for Recuperative Care services to a CalOptima or Health Network Member who meets the established criteria defined in Section III.I.4.b. of this Policy, Attachment B of this Policy, and when delay of an authorization would be harmful to the Member.

2. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) who were previously identified and receiving Community Supports, CalOptima shall:

a. Authorize the Member for Community Supports upon:

i. A direct request from the Member, the Member's family or authorized representative to include an attestation from the Member.

ii. Review of Encounter data demonstrating Community Supports utilization in previous ninety (90) days when available.

b. Outreach to the Member, the Member's previous MCP, and/or the Community Supports provider, as appropriate to mitigate gaps in care.

i. Members will be reassessed based on the following discontinuation criteria:

1) Member states they no longer wish to receive the service;

2) Provider is unable to reach Member after multiple attempts;

3) Member no longer requires the service or has completed service goals; or

4) Member is unresponsive or unwilling to engage with the Community Supports provider. This can include instances when a Member's behavior or environment is unsafe for the Community Supports Provider.

c. CalOptima shall not authorize Community Supports for a Member who transitions from another MCP when the Community Support service is only available once in a Member's lifetime and/or if CalOptima does not provide the Community Support service which the Member had received from the Member's prior MCP.

~~2.~~3. CalOptima shall notify the requestor of CalOptima's decision regarding CalOptima Community Supports service authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

~~3.~~4. CalOptima shall monitor and evaluate CalOptima Community Supports authorizations to ensure they are equitable and non-discriminatory in accordance with Section III.M. of this Policy.

F. Sharing Information with Community Supports Providers

1. As part of the referral process to Community Supports Providers and consistent with federal, State, and, if applicable, local privacy and confidentiality laws, CalOptima shall ensure a Community Supports Provider has access to:

a. Demographic and administrative information confirming the Member's eligibility and authorization for the requested service;

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b. Appropriate administrative, clinical, and social service information the Community Supports Provider may need to effectively provide the requested service; and

c. Billing information necessary to enable the Community Supports Provider to submit claims or invoices to CalOptima.

2. CalOptima shall provide the following data elements to Community Supports Providers in a manner and format that is practical to each Community Supports Provider:

a. Member assignment files, including but may not be limited to:

i. Encounter and claims data;

ii. Physical, behavioral, administrative and Social Determinants of Health data; and

iii. Report of Community Supports Provider performance and quality metrics, as requested.

G. Community Supports Provider Responsibilities Upon Authorization

1. Community Supports Providers shall:

a. Accept and act upon referrals for authorized CalOptima Community Supports, unless the Community Supports Provider is at pre-determined capacity.

b. Conduct outreach to the referred Member for authorized CalOptima Community Supports as soon as possible, within twenty-four (24) hours of assignment, if possible.

i. As part of service initiation, secure, document, and preserve evidence of Member agreement to receive CalOptima Community Supports before providing such services.

c. Be responsive to incoming calls or other outreach from Members; maintain a phone line that is staffed or able to record voicemail twenty-four (24) hours a day, seven (7) days per week.

d. Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and CalOptima or the Health Network, as applicable.

e. Comply with cultural competency and linguistic requirements in accordance with federal, State and local laws, the Community Supports Provider's contract with CalOptima, and CalOptima Policy DD.2002: Cultural and Linguistic Services.

f. Comply with applicable federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by federal and State nondiscrimination laws and in accordance with the Community Supports Provider's contract with CalOptima, and CalOptima Policy HH.1104: Complaints of Discrimination.

g. Coordinate with other entities to ensure the Member has access to appropriate supports, including, but not limited to Orange County Public Health, Orange County Behavioral Health Services and Social Services.

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h. Support transition planning into other programs or services that meet the Member's needs when a CalOptima Community Support is discontinued for any reason.

i. Utilize best practices for Members experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2. When federal law requires authorization for data sharing, Community Supports Providers shall obtain and document such authorization from each assigned Member, including sharing protected health information (PHI), and confirm it has obtained such authorization to CalOptima.

3. Community Supports Providers are encouraged to identify additional CalOptima Community Supports that may benefit a Member and send any additional request(s) for CalOptima Community Supports to CalOptima or the Member's Health Network, as applicable, for authorization.

H. Billing for Community Supports

1. For CalOptima and Health Network Members, except for Members enrolled in a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports, a Community Supports Provider shall submit claims to CalOptima for CalOptima Community Supports services provided.

a. The claims shall be based on specifications from the DHCS-defined code sets and national standards.

b. If the Community Supports Provider is unable to submit claims using such specifications, an invoice shall be submitted, with DHCS-defined minimum necessary data elements that support conversion of the invoice to a DHCS-defined specification and code set for submission to DHCS, including, but not limited to:

i. Member;

ii. CalOptima Community Supports services rendered; and

iii. Community Supports Provider.

2. A Community Supports Provider shall submit CalOptima Community Supports claims or invoices for a Member assigned to a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports to the HMO for processing.

I. Community Supports Provider Qualifications and Service Transition Criteria for existing and future CalOptima covered services: CalOptima Community Supports will be provided to Members by contracted Community Supports Providers in accordance with the following requirements based on CalOptima's current and future board and DHCS approved offerings:

1. Housing Transition Navigation Services

a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

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ii. Strong relationships with local housing authorities;

iii. Demonstrated local experience in the provision of Housing Transition Navigation Services, including housing-related services and supports; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Transition Navigation Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until such time as the Member:

i. Is successfully placed in permanent housing, and transitioned to Housing Tenancy and Sustaining Services, as appropriate;

ii. Refuses Housing Transition Navigation Services;

iii. Loses funding and/or a housing voucher, where no resolution of the loss exists;

iv. Is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

v. Is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Housing Transition Navigation Services at an appropriate frequency for the needs of the Member, considering the specific barriers that exist for that Member and shall ensure seamless service to Members entering Housing Transition Navigation Services.

2. Housing Deposits

a. Minimum provider qualifications include:

i. Understanding of federal, State and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated or verifiable experience in providing these unique services; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Deposits, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until the Member:

i. Refuses Housing Transition Navigation Services (at a minimum, tenant screening, housing assessment and individualized housing support);

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ii. Is no longer physically, cognitively or emotionally stable to reside in independent, supported housing; or

iii. Loses eligibility with CalOptima or a Health Network.

3. Housing Tenancy and Sustaining Services

a. Minimum provider qualifications include:

i. Understanding of federal, State and local transitional and permanent supporting housing programs and requirements;

ii. Demonstrated or verifiable experience in providing housing-related services and supports; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Tenancy and Sustaining Services, as described in Attachment A of this Policy, are provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. The Member's housing support plan determines they are no longer needed;

ii. The Member refuses Housing Tenancy and Sustaining Services;

iii. Loss of funding and/or housing voucher, where no resolution of the loss exists;

iv. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

v. The Member is no longer eligible with CalOptima or a Health Network.

4. Recuperative Care

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Recuperative Care;

ii. Services are provided in compliance with the National Standards for Recuperative Care Programs; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Recuperative Care, as described in Attachment A of this Policy, is provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

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i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member has received ninety (90) continuous days of Recuperative Care;

iii. The Member refuses Recuperative Care; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. ~~Excluding Members assigned to Kaiser,~~ CalOptima ~~contracted Recuperative Care Providers may presumptively authorize~~will assess the need for presumptive eligibility and continuously evaluate and ensure these services ~~to~~ meet urgent Member needs who may be harmed by a delay in authorization (*e.g.*, hospital discharge for a Member eligible for Recuperative Care whose discharge plan is pending authorization). Presumptive authorization will be valid for no longer than fourteen (14) days total from date of admission into the Recuperative Care facility.

~~i. Presumptive authorization will be valid for no longer than two (2) business days after admission into the Recuperative Care facility.~~

~~ii.~~i. Formal authorization from CalOptima or a Health Network must be obtained for the Recuperative Care stay.

1) The CalOptima Recuperative Care Provider is responsible for immediate submission of a request for Recuperative Care to CalOptima or a Health Network, including for those days presumptively authorized by the Recuperative Care Provider, the authorization request shall include:

a) The request form and medical information including, but not limited to: discharge instructions, discharge summary, referral(s) for home health or durable medical equipment (DME), as appropriate, post-discharge medications and post discharge follow-up appointment provider, date and time.

d. A Recuperative Care Provider shall submit Recuperative Care authorization for Members assigned to Kaiser Members to Kaiser for determination.

5. Short-term Post-Hospitalization Housing

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Short-term post Hospitalization Housing for Members with high medical or behavioral health needs;

ii. Understanding of federal, State and local transitional and permanent supporting housing programs and their requirements;

iii. Strong relationships with local housing authorities;

iv. Demonstrated or verifiable experience in providing these unique services; and

v. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

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b. Short-term Post-Hospitalization Housing, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member refuses Short-term Post-Hospitalization Housing;

iii. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Short-Term Post-Hospitalization Services at an appropriate frequency for the needs of the Member and not to exceed a six (6) month duration.

6. Medically-Tailored Meals

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Medically-Tailored Meals, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer medically necessary or required for the Member;

ii. The Member refuses Medically-Tailored Meals Services;

iii. The Member has received medically-supportive food and nutrition services for up to 12 weeks as appropriate; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

7. Sobering Centers

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population;

ii. Established working relationships with County behavioral health agency;

iii. Strong relationships with law enforcement, emergency personnel, and community outreach partners to identify and divert individuals to Sobering Centers; and

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iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Sobering Centers, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary or required for the Member;

ii. The duration of services received by the Member approaches the limit (less than twenty-four (24) hours); or

iii. The Member is no longer eligible with CalOptima or a Health Network.

8. Personal Care/Homemaker Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Personal Care/Homemaker Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Personal Care/Homemaker Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

9. Day Habilitation Program

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services;

ii. Services are provided in compliance with the National Standards for Adult Day Service Programs; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Day Habilitation Program, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

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i. Services are no longer necessary for the Member;

ii. The Member refuses Day Habilitation Program Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

10. Respite Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Respite Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member has reached the three hundred thirty-six (336) hour annual limit; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

11. Nursing Facility Transition for Elderly and Adult Residential Facilities

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Nursing Facility services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Nursing Facility Transition for Elderly and Adult Residential Facilities, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Nursing Facility Transition for Elderly and Adult Residential Facilities Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

12. Community Transition Services/Nursing Facility Transition to Home

a. Minimum provider qualifications include:

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i. Demonstrated or verifiable experience and expertise in providing Community Transition Services/Nursing Facility Transition to Home services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Community Transition Services/ Nursing Facility Transition to Home, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Community Transition Services/ Nursing Facility Transition to Home Services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

13. Environmental Accessibility Adaptations

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Environmental Accessibility Adaptations

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Environmental Accessibility Adaptations, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Environmental Accessibility Adaptations

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

14. Asthma Remediation

a. Minimum provider qualifications include:

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i. Demonstrated or verifiable experience and expertise in providing Asthma Remediation services;

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

c. Asthma Remediation, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Asthma Remediation services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

J. CalOptima or a Health Network shall track referrals to a Community Supports Provider to verify that authorized services have been initiated for the Member.

K. CalOptima or a Health Network will receive regular updates from the Community Supports Provider about the Member's progress toward goals, changes in status or barriers and other significant information affecting CalOptima Community Supports for the Member.

1. A Health Network shall provide data to CalOptima about the ongoing monitoring of appropriate and timely delivery of CalOptima Community Supports to their Members in a manner and format defined by CalOptima and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

L. CalOptima shall ensure timely and accurate processing of claims for CalOptima Community Supports in accordance with applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance and CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

M. Oversight of CalOptima Community Supports

1. CalOptima shall perform oversight of Community Supports Providers and hold Community Supports Providers accountable for all regulatory and contractual requirements, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

a. CalOptima shall hold Community Supports Providers responsible for the same reporting requirements as those that CalOptima must report to DHCS.

b. CalOptima will not impose upon the Community Supports Providers mandatory reporting requirements that are different from or in addition to those required for encounter and supplemental reporting.

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2. CalOptima may subcontract with other entities to administer CalOptima Community Supports, and must comply with all of the following:

    a. CalOptima will maintain and be responsible for compliance oversight of all contract provisions and covered services, regardless of the number of subcontracting layers.

        i. Subcontractor agreements will mirror the DHCS ECM and CalOptima Community Supports contract template requirements and the ECM and Community Supports Provider Standard Terms and Conditions.

    b. CalOptima shall retain responsibility for development and maintenance of DHCS-approved policies and procedures to ensure that subcontractors meet required responsibilities and functions.

    c. CalOptima shall be responsible for evaluating prospective subcontractor's ability to perform services.

    d. CalOptima is responsible for ensuring that subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members.

    e. CalOptima will report to the DHCS the names of all subcontractors by type and service(s) provided and identify Orange County as the county in which Members are served.

        i. CalOptima will make all subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum required information specified by DHCS, including method and amount of compensation.

3. On a quarterly basis, CalOptima shall review CalOptima Community Supports authorizations to ensure equitable and non-discriminatory approval determinations.

    a. CalOptima will evaluate the ethnic and racial characteristics of the population for whom CalOptima Community Supports is requested against the same characteristics of the population that was authorized for CalOptima Community Supports and provide feedback on the assessment. If CalOptima identifies an inequitable effect, CalOptima will refer the issue to the Audit and Oversight Department for continued action, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

    b. CalOptima shall monitor healthcare service utilization and outcomes of member populations receiving CalOptima Community Supports as follows:

        i. On a monthly basis, CalOptima shall monitor the housing status and program participation for each Member receiving housing-related CalOptima Community Supports.

        ii. On a semi-annual basis, CalOptima shall monitor emergency room visits and hospitalizations for Members receiving Recuperative Care and analyze utilization prior to and after initiation of services.

N. CalOptima shall submit the following data and reports in a manner, format and frequency as defined by DHCS:

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1. Encounter data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS, including services generated under subcontracting arrangements~~; and~~.

2. Data will be provided to:

   a. Evaluate the utilization and effectiveness of a Community Support;

   b. Monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken; and

   c. Monitor Member appeals and grievances associated with Community Supports.

~~2.~~3. Supplemental reports, on a schedule and in a format as specified by DHCS.

IV. ATTACHMENT(S)

A. Community Supports Components
B. Community Supports Eligibility (Population Subset)
~~C. CalAIM Community Supports Referral Form~~

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
B. Department of Health Care Services (DHCS) Managed Care Plan ECM and ILOS Contract Template
C. CalAIM ECM and ~~ILOS~~Community Supports Model of Care Template
D. Medi-Cal ~~In Lieu of Services (ILOS)~~Community Supports Policy Guide (~~September~~December 2021)
E. CalOptima Contract for Health Care Services
F. CalOptima Policy DD.2002: Cultural and Linguistic Services
G. CalOptima Policy EE.1103Δ: Provider Education and Training
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy FF.2001: Claims Processing for Covered Services which CalOptima is Financially Responsible
J. CalOptima Policy GG.1353: Enhanced Care Management (ECM) Service Delivery
K. CalOptima Policy GG.1356: Enhanced Care Management (ECM) Administration
L. CalOptima Policy GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
M. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
N. CalOptima Policy GG.1508 Authorization and Processing of Referrals
O. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners and
P. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
Q. CalOptima Policy HH.1101: CalOptima Provider Complaint
R. CalOptima Policy HH.1102: Member Grievance
S. CalOptima Policy HH.1104: Complaints of Discrimination
T. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
U. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring

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V. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	Regulatory Agency	Response
11/30/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1355	Community Supports	Medi-Cal
Revised	TBD	GG.1355	Community Supports	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
California Medicaid State Plan	A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.
CalOptima Community Supports	Community Supports that CalOptima has received approval from the Department of Health Care Services (DHCS) to provide.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of the DHCS-approved CalOptima Community Supports. Providers are entities with experience and expertise providing one (1) or more of the CalOptima Community Supports approved by the DHCS.

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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, 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 Enhanced Care Management and CalOptima Community Supports (as provided under the California Advancing and Innovating Medi-Cal initiative) for Members meeting eligibility criteria, 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.
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
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high ~~-~~cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	~~Providers~~A Provider within the community that ~~have~~has a contractual relationship with CalOptima~~, or CalOptima acting directly,~~ (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
Encounter	Any unit of Covered Services provided to a member by a Health Network regardless of reimbursement methodology.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
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.

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Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Recuperative Care	Short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

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Policy:	GG.1355
Title:	**Community Supports**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

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I. PURPOSE

This Policy describes the eligibility criteria for CalOptima Community Supports and identifies the requirements for the referral, authorization, and provision of CalOptima Community Supports under the California Advancing and Innovating Medi-Cal (CalAIM) initiative.

II. POLICY

A. Community Supports are medically appropriate, cost-effective alternatives provided as a substitute to services covered under the California Medicaid State Plan and are delivered by a different Provider or in a different setting than those described in the State Plan. These services shall not reduce or jeopardize Members' access to State Plan services.

B. Community Supports can only be covered if the State determines they are medically appropriate and cost-effective alternatives and are identified and authorized in CalOptima's Medi-Cal Contract with the Department of Health Care Services (DHCS).

C. A Member's participation in CalOptima Community Supports is optional; CalOptima shall not require a Member to use CalOptima Community Supports.

D. CalOptima shall ensure the underlying State Plan Covered Services are made available to the Member, if Medically Necessary for the Member, or if the Member declines CalOptima Community Supports.

E. CalOptima shall provide public notice of any limitations on Community Supports when an alternative approach involving narrowing eligible populations, including specifying such limitations in the Member Handbook/Evidence of Coverage and website, in addition to receiving written approval from DHCS.

F. To the extent a Member is receiving care or case management, CalOptima Community Supports should be integrated with care or case management, including Enhanced Care Management (ECM) when appropriate.

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G. CalOptima may delegate CalOptima Community Supports to Kaiser Foundation Health Plan (Kaiser), in accordance with the CalOptima Contract for Health Care Services and the Delegation Agreement.

H. Effective no sooner than January 1, 2022, CalOptima shall offer four (4) selected DHCS-approved CalOptima Community Supports, listed below and further defined in Attachment A of this Policy.

1. Housing Transition Navigation Services;
2. Housing Deposits;
3. Housing Tenancy and Sustaining Services; and
4. Recuperative Care (Medical Respite).

I. In the event that CalOptima expands Community Supports, the following services listed below may be considered and are further defined in Attachment A of this Policy.

1. Short-Term Post-Hospitalization Housing;
2. Medically-Tailored meals;
3. Sobering Centers;
4. Personal Care/Homemaker Services; and
5. Day Habilitation Program
6. Respite Services;
7. Nursing Facility Transition/Diversion to Assisted Living Facilities (Elderly and Adult Residential Facilities);
8. Community Transition Services/Nursing Facility Transition to a Home;
9. Environmental Accessibility Adaptions (Modifications); and
10. Asthma Remediation.

J. CalOptima will notify DHCS of any additional community support offering with six (6) months' notice and include submission of an updated CalAIM Model of Care to DHCS.

K. CalOptima shall provide CalOptima Community Supports training and technical assistance to Community Supports Providers, through in-person sessions, webinars, and/or telephone calls, as necessary and in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training and Section III.C. of this Policy.

L. A Community Supports Provider shall not receive payment from CalOptima for the provision of any CalOptima Community Supports not authorized by CalOptima or a Health Network.

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M. To be eligible for participation in CalOptima Community Supports, a Member must meet the DHCS-specific requirements for the CalOptima Community Supports under consideration, as described in Attachment B of this Policy.

O. CalOptima or a Health Network shall accept referrals for CalOptima Community Supports from Providers, other community-based entities, Members and/or family members.

P. CalOptima or the Health Network shall use systems and processes capable of tracking CalOptima Community Supports referrals, access to CalOptima Community Supports, and Grievances and Appeals.

1. CalOptima or the Health Network shall track CalOptima Community Supports referrals and will support Community Supports Provider access to systems and processes allowing them to track and manage referral and Member information.

Q. CalOptima shall regularly monitor and provide oversight of Community Supports Providers to ensure compliance with regulatory, contractual, and business requirements as described in Section III.M. of this Policy.

R. A Community Supports Provider or Member, as applicable, shall be entitled to Grievance and Appeals procedures in accordance with CalOptima Policies GG.1510: Appeal Process, HH.1101: CalOptima Provider Complaint, and HH.1102: Member Grievance.

S. CalOptima Community Supports are subject to the State Fair Hearings process, in accordance with CalOptima Policy HH.1108: State Hearing Process and Procedures.

III. PROCEDURE

A. Informing Members and Providers

1. CalOptima shall inform Members and Providers about current and newly added CalOptima-offered Community Supports and the referral process, including how to submit the CalOptima Community Supports request through:

a. Member communication such as the Member Handbook, CalOptima website, Member Orientation meetings, and communication with CalOptima representatives (e.g., Customer Service staff, case managers); and

b. Provider communication including but not limited to the CalOptima website (www.caloptima.org), CalOptima Provider Manual, CalOptima Policies and Procedures, CalOptima Community Announcement, other educational materials, as well as through community events and other regularly scheduled CalOptima stakeholder forums.

2. CalOptima may discontinue a specific CalOptima Community Supports annually, with notice to DHCS, at the end of the calendar year, except in cases where the CalOptima Community Supports is terminated due to Member health, safety, or welfare concerns.

a. CalOptima shall ensure CalOptima Community Supports that were authorized for a Member prior to the discontinuation of that specific CalOptima Community Supports are not disrupted by a change in CalOptima Community Supports offerings, either by completing the authorized services or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet their needs.

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b. CalOptima shall publicize the service end date and provide at least ninety (90) calendar days' notice to Members. Notice to Members affected by a decision to discontinue a specific CalOptima Community Supports shall include:

i. The change and timing of discontinuation; and

ii. The procedures that will be used to ensure completion of the authorized CalOptima Community Supports or a transition into other Medically Necessary services.

c. CalOptima shall implement a plan for continuity of care for Members receiving the discontinued CalOptima Community Supports.

B. Provider Medi-Cal Enrollment and Credentialing or CalOptima's Vetting Process

1. If a State level enrollment pathway exists for the Community Supports Provider, CalOptima shall verify that the Community Supports Provider is enrolled in Medi-Cal, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima shall also credential the Community Supports Provider in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Assessment and Re-Assessment of Organizational Providers, as applicable.

2. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima shall verify the qualifications of the Provider or provider organization to ensure they meet the standards and capabilities to be a Community Supports Provider in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring. CalOptima shall also consider the following factors as part of CalOptima's process for vetting the qualifications and experience of Community Supports Providers:

a. Ability to receive referrals from CalOptima and Health Networks for the authorized CalOptima Community Supports service;

b. Sufficient experience to provide services similar to the specific CalOptima Community Supports they are contracted to provide within the service area;

c. Ability to submit claims or invoices for CalOptima Community Supports using standardized protocols;

d. Business licensing that meets industry standards;

e. Capability to comply with all reporting and oversight requirements;

f. History of fraud, waste, and/or abuse;

g. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

h. History of liability claims against the Community Supports Provider.

C. Provider Training

1. In addition to network Provider training requirements described in CalOptima's Medi-Cal Contract with DHCS, CalOptima will provide the CalOptima Community Supports training

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described below to Community Supports Providers, including through in-person sessions, webinars, and/or calls, as necessary:

a. CalOptima Community Supports program overview, Community Supports Provider role, community resources and referrals, as well as operational and topic-specific trainings.

b. Special populations, Social Determinants of Health, trauma-informed care, health literacy, data-sharing and reporting requirements will also be covered.

D. Identifying Members and Receiving Requests for CalOptima Community Supports

1. CalOptima and the Health Networks shall identify Members who will benefit from one or more CalOptima Community Supports by:

a. Working with ECM Providers to identify Members receiving ECM who could benefit from CalOptima Community Supports;

b. Proactively identifying Members who may benefit from the CalOptima Community Supports through review of available data indicating a Member meets specific eligibility criteria, as described in Attachment B of this Policy;

c. Accepting CalOptima Community Supports requests from Providers and other community-based entities; and

d. Accepting CalOptima Community Supports requests from a Member, family member, guardian, caregiver, and/or authorized support person.

2. CalOptima shall refer Members to a Community Supports Provider within two (2) business days of issuing authorization for the service.

3. CalOptima shall provide Medically Necessary Covered Services regardless of whether the Member has been offered a Community Support, is currently receiving a Community Support, or has received a Community Support in the past.

4. If a Community Supports Provider capacity is limited, CalOptima or a Health Network shall prioritize the initiation of CalOptima Community Supports to Members who:

a. Meet all CalOptima Community Supports criteria; and

b. Demonstrate a high level of commitment to participating in services.

E. Authorization of CalOptima Community Supports is required prior to the initiation of services.

1. CalOptima shall ensure timely processing of expedited and routine CalOptima Community Supports authorization requests in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers and GG.1508: Authorization and Processing of Referrals.

a. An authorization request for CalOptima Community Supports may be expedited when a specific, time-limited indication for the service requested exists and is a critical component of appropriate delivery of the CalOptima Community Supports.

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i. Recuperative Care Providers may issue a presumptive authorization for Recuperative Care services to a CalOptima or Health Network Member who meets the established criteria defined in Section III.I.4.b. of this Policy, Attachment B of this Policy, and when delay of an authorization would be harmful to the Member.

2. For Members transitioning from other Medi-Cal Managed Care Plans (MCPs) who were previously identified and receiving Community Supports, CalOptima shall:

a. Authorize the Member for Community Supports upon:

i. A direct request from the Member, the Member's family or authorized representative to include an attestation from the Member.

ii. Review of Encounter data demonstrating Community Supports utilization in previous ninety (90) days when available.

b. Outreach to the Member, the Member's previous MCP, and/or the Community Supports provider, as appropriate to mitigate gaps in care.

i. Members will be reassessed based on the following discontinuation criteria:

1) Member states they no longer wish to receive the service;

2) Provider is unable to reach Member after multiple attempts;

3) Member no longer requires the service or has completed service goals; or

4) Member is unresponsive or unwilling to engage with the Community Supports provider. This can include instances when a Member's behavior or environment is unsafe for the Community Supports Provider.

c. CalOptima shall not authorize Community Supports for a Member who transitions from another MCP when the Community Support service is only available once in a Member's lifetime and/or if CalOptima does not provide the Community Support service which the Member had received from the Member's prior MCP.

3. CalOptima shall notify the requestor of CalOptima's decision regarding CalOptima Community Supports service authorization in accordance with CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.

4. CalOptima shall monitor and evaluate CalOptima Community Supports authorizations to ensure they are equitable and non-discriminatory in accordance with Section III.M. of this Policy.

F. Sharing Information with Community Supports Providers

1. As part of the referral process to Community Supports Providers and consistent with federal, State, and, if applicable, local privacy and confidentiality laws, CalOptima shall ensure a Community Supports Provider has access to:

a. Demographic and administrative information confirming the Member's eligibility and authorization for the requested service;

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b. Appropriate administrative, clinical, and social service information the Community Supports Provider may need to effectively provide the requested service; and

c. Billing information necessary to enable the Community Supports Provider to submit claims or invoices to CalOptima.

2. CalOptima shall provide the following data elements to Community Supports Providers in a manner and format that is practical to each Community Supports Provider:

a. Member assignment files, including but may not be limited to:

i. Encounter and claims data;

ii. Physical, behavioral, administrative and Social Determinants of Health data; and

iii. Report of Community Supports Provider performance and quality metrics, as requested.

G. Community Supports Provider Responsibilities Upon Authorization

1. Community Supports Providers shall:

a. Accept and act upon referrals for authorized CalOptima Community Supports, unless the Community Supports Provider is at pre-determined capacity.

b. Conduct outreach to the referred Member for authorized CalOptima Community Supports as soon as possible, within twenty-four (24) hours of assignment, if possible.

i. As part of service initiation, secure, document, and preserve evidence of Member agreement to receive CalOptima Community Supports before providing such services.

c. Be responsive to incoming calls or other outreach from Members; maintain a phone line that is staffed or able to record voicemail twenty-four (24) hours a day, seven (7) days per week.

d. Coordinate with other Providers in the Member's care team, including ECM Providers, other Community Supports Providers and CalOptima or the Health Network, as applicable.

e. Comply with cultural competency and linguistic requirements in accordance with federal, State and local laws, the Community Supports Provider's contract with CalOptima, and CalOptima Policy DD.2002: Cultural and Linguistic Services.

f. Comply with applicable federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by federal and State nondiscrimination laws and in accordance with the Community Supports Provider's contract with CalOptima, and CalOptima Policy HH.1104: Complaints of Discrimination.

g. Coordinate with other entities to ensure the Member has access to appropriate supports, including, but not limited to Orange County Public Health, Orange County Behavioral Health Services and Social Services.

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h. Support transition planning into other programs or services that meet the Member's needs when a CalOptima Community Support is discontinued for any reason.

i. Utilize best practices for Members experiencing homelessness and who have complex health, disability, and/or behavioral health conditions.

2. When federal law requires authorization for data sharing, Community Supports Providers shall obtain and document such authorization from each assigned Member, including sharing protected health information (PHI), and confirm it has obtained such authorization to CalOptima.

3. Community Supports Providers are encouraged to identify additional CalOptima Community Supports that may benefit a Member and send any additional request(s) for CalOptima Community Supports to CalOptima or the Member's Health Network, as applicable, for authorization.

H. Billing for Community Supports

1. For CalOptima and Health Network Members, except for Members enrolled in a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports, a Community Supports Provider shall submit claims to CalOptima for CalOptima Community Supports services provided.

a. The claims shall be based on specifications from the DHCS-defined code sets and national standards.

b. If the Community Supports Provider is unable to submit claims using such specifications, an invoice shall be submitted, with DHCS-defined minimum necessary data elements that support conversion of the invoice to a DHCS-defined specification and code set for submission to DHCS, including, but not limited to:

i. Member;

ii. CalOptima Community Supports services rendered; and

iii. Community Supports Provider.

2. A Community Supports Provider shall submit CalOptima Community Supports claims or invoices for a Member assigned to a Health Maintenance Organization (HMO) responsible for CalOptima Community Supports to the HMO for processing.

I. Community Supports Provider Qualifications and Service Transition Criteria for existing and future CalOptima covered services: CalOptima Community Supports will be provided to Members by contracted Community Supports Providers in accordance with the following requirements based on CalOptima's current and future board and DHCS approved offerings:

1. Housing Transition Navigation Services

a. Minimum provider qualifications include:

i. Understanding of federal, State, and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

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iii. Demonstrated local experience in the provision of Housing Transition Navigation Services, including housing-related services and supports; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Transition Navigation Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until such time as the Member:

i. Is successfully placed in permanent housing, and transitioned to Housing Tenancy and Sustaining Services, as appropriate;

ii. Refuses Housing Transition Navigation Services;

iii. Loses funding and/or a housing voucher, where no resolution of the loss exists;

iv. Is no longer physically, cognitively, or emotionally able to reside in independent, supported housing; or

v. Is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Housing Transition Navigation Services at an appropriate frequency for the needs of the Member, considering the specific barriers that exist for that Member and shall ensure seamless service to Members entering Housing Transition Navigation Services.

2. Housing Deposits

a. Minimum provider qualifications include:

i. Understanding of federal, State and local transitional and permanent supporting housing programs and their requirements;

ii. Strong relationships with local housing authorities;

iii. Demonstrated or verifiable experience in providing these unique services; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Deposits, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until the Member:

i. Refuses Housing Transition Navigation Services (at a minimum, tenant screening, housing assessment and individualized housing support);

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ii. Is no longer physically, cognitively or emotionally stable to reside in independent, supported housing; or

iii. Loses eligibility with CalOptima or a Health Network.

3. Housing Tenancy and Sustaining Services

a. Minimum provider qualifications include:

i. Understanding of federal, State and local transitional and permanent supporting housing programs and requirements;

ii. Demonstrated or verifiable experience in providing housing-related services and supports; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Housing Tenancy and Sustaining Services, as described in Attachment A of this Policy, are provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. The Member's housing support plan determines they are no longer needed;

ii. The Member refuses Housing Tenancy and Sustaining Services;

iii. Loss of funding and/or housing voucher, where no resolution of the loss exists;

iv. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

v. The Member is no longer eligible with CalOptima or a Health Network.

4. Recuperative Care

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Recuperative Care;

ii. Services are provided in compliance with the National Standards for Recuperative Care Programs; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Recuperative Care, as described in Attachment A of this Policy, is provided to a Member meeting the criteria as provided in Attachment B to this Policy by a Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member, and a discharge plan has been established;

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ii. The Member has received ninety (90) continuous days of Recuperative Care;

iii. The Member refuses Recuperative Care; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. CalOptima will assess the need for presumptive eligibility and continuously evaluate and ensure these services meet urgent Member needs who may be harmed by a delay in authorization (*e.g.*, hospital discharge for a Member eligible for Recuperative Care whose discharge plan is pending authorization). Presumptive authorization will be valid for no longer than fourteen (14) days total from date of admission into the Recuperative Care facility.

i. Formal authorization from CalOptima or a Health Network must be obtained for the Recuperative Care stay.

1) The CalOptima Recuperative Care Provider is responsible for immediate submission of a request for Recuperative Care to CalOptima or a Health Network, including for those days presumptively authorized by the Recuperative Care Provider, the authorization request shall include:

a) The request form and medical information including, but not limited to: discharge instructions, discharge summary, referral(s) for home health or durable medical equipment (DME), as appropriate, post-discharge medications and post discharge follow-up appointment provider, date and time.

d. A Recuperative Care Provider shall submit Recuperative Care authorization for Members assigned to Kaiser Members to Kaiser for determination.

5. Short-term Post-Hospitalization Housing

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Short-term post Hospitalization Housing for Members with high medical or behavioral health needs;

ii. Understanding of federal, State and local transitional and permanent supporting housing programs and their requirements;

iii. Strong relationships with local housing authorities;

iv. Demonstrated or verifiable experience in providing these unique services; and

v. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Short-term Post-Hospitalization Housing, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

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i. Services are no longer required for the Member, and a discharge plan has been established;

ii. The Member refuses Short-term Post-Hospitalization Housing;

iii. The Member is no longer physically, cognitively or emotionally able to reside in independent, supported housing; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

c. A Community Supports Provider shall provide Short-Term Post-Hospitalization Services at an appropriate frequency for the needs of the Member and not to exceed a six (6) month duration.

6. Medically-Tailored Meals

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Medically-Tailored Meals, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer medically necessary or required for the Member;

ii. The Member refuses Medically-Tailored Meals Services;

iii. The Member has received medically-supportive food and nutrition services for up to 12 weeks as appropriate; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

7. Sobering Centers

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population;

ii. Established working relationships with County behavioral health agency;

iii. Strong relationships with law enforcement, emergency personnel, and community outreach partners to identify and divert individuals to Sobering Centers; and

iv. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

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b. Sobering Centers, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary or required for the Member;

ii. The duration of services received by the Member approaches the limit (less than twenty-four (24) hours); or

iii. The Member is no longer eligible with CalOptima or a Health Network.

8. Personal Care/Homemaker Services

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services for this unique population; and

ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Personal Care/Homemaker Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Personal Care/Homemaker Services; or

iii. The Member is no longer eligible with CalOptima or a Health Network.

9. Day Habilitation Program

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing unique services;

ii. Services are provided in compliance with the National Standards for Adult Day Service Programs; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Day Habilitation Program, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer necessary for the Member;

ii. The Member refuses Day Habilitation Program Services; or

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iii. The Member is no longer eligible with CalOptima or a Health Network.

10. Respite Services

    a. Minimum provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing unique services; and

        ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

    b. Respite Services, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

        i. Services are no longer required for the Member;

        ii. The Member has reached the three hundred thirty-six (336) hour annual limit; or

        iii. The Member is no longer eligible with CalOptima or a Health Network.

11. Nursing Facility Transition for Elderly and Adult Residential Facilities

    a. Minimum provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Nursing Facility services; and

        ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

    b. Nursing Facility Transition for Elderly and Adult Residential Facilities, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

        i. Services are no longer required for the Member;

        ii. The Member refuses Nursing Facility Transition for Elderly and Adult Residential Facilities Services; or

        iii. The Member is no longer eligible with CalOptima or a Health Network.

12. Community Transition Services/Nursing Facility Transition to Home

    a. Minimum provider qualifications include:

        i. Demonstrated or verifiable experience and expertise in providing Community Transition Services/Nursing Facility Transition to Home services; and

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ii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring

b. Community Transition Services/ Nursing Facility Transition to Home, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Community Transition Services/ Nursing Facility Transition to Home Services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

13. Environmental Accessibility Adaptations

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Environmental Accessibility Adaptations

ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

b. Environmental Accessibility Adaptations, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Environmental Accessibility Adaptations

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

14. Asthma Remediation

a. Minimum provider qualifications include:

i. Demonstrated or verifiable experience and expertise in providing Asthma Remediation services;

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ii. Services are provided in compliance with applicable State and local building codes; and

iii. Successful completion of CalOptima's pre-contractual review in accordance with CalOptima Policy GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring.

c. Asthma Remediation, as described in Attachment A of this Policy, will be provided to a Member meeting the criteria as provided in Attachment B to this Policy by the Community Supports Provider when authorized by CalOptima or a Health Network until:

i. Services are no longer required for the Member;

ii. The Member refuses Asthma Remediation services;

iii. The Member has reached the total lifetime maximum of $7,500 and does not have an approved exception; or

iv. The Member is no longer eligible with CalOptima or a Health Network.

J. CalOptima or a Health Network shall track referrals to a Community Supports Provider to verify that authorized services have been initiated for the Member.

K. CalOptima or a Health Network will receive regular updates from the Community Supports Provider about the Member's progress toward goals, changes in status or barriers and other significant information affecting CalOptima Community Supports for the Member.

1. A Health Network shall provide data to CalOptima about the ongoing monitoring of appropriate and timely delivery of CalOptima Community Supports to their Members in a manner and format defined by CalOptima and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

L. CalOptima shall ensure timely and accurate processing of claims for CalOptima Community Supports in accordance with applicable statutory, regulatory, and contractual requirements, as well as DHCS guidance and CalOptima Policy FF.2001: Claims Processing for Covered Services for which CalOptima is Financially Responsible.

M. Oversight of CalOptima Community Supports

1. CalOptima shall perform oversight of Community Supports Providers and hold Community Supports Providers accountable for all regulatory and contractual requirements, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

a. CalOptima shall hold Community Supports Providers responsible for the same reporting requirements as those that CalOptima must report to DHCS.

b. CalOptima will not impose upon the Community Supports Providers mandatory reporting requirements that are different from or in addition to those required for encounter and supplemental reporting.

2. CalOptima may subcontract with other entities to administer CalOptima Community Supports, and must comply with all of the following:

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a. CalOptima will maintain and be responsible for compliance oversight of all contract provisions and covered services, regardless of the number of subcontracting layers.

i. Subcontractor agreements will mirror the DHCS ECM and CalOptima Community Supports contract template requirements and the ECM and Community Supports Provider Standard Terms and Conditions.

b. CalOptima shall retain responsibility for development and maintenance of DHCS-approved policies and procedures to ensure that subcontractors meet required responsibilities and functions.

c. CalOptima shall be responsible for evaluating prospective subcontractor's ability to perform services.

d. CalOptima is responsible for ensuring that subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members.

e. CalOptima will report to the DHCS the names of all subcontractors by type and service(s) provided and identify Orange County as the county in which Members are served.

i. CalOptima will make all subcontractor agreements available to DHCS upon request. Such agreements must contain the minimum required information specified by DHCS, including method and amount of compensation.

3. On a quarterly basis, CalOptima shall review CalOptima Community Supports authorizations to ensure equitable and non-discriminatory approval determinations.

a. CalOptima will evaluate the ethnic and racial characteristics of the population for whom CalOptima Community Supports is requested against the same characteristics of the population that was authorized for CalOptima Community Supports and provide feedback on the assessment. If CalOptima identifies an inequitable effect, CalOptima will refer the issue to the Audit and Oversight Department for continued action, in accordance with CalOptima Policy GG.1619: Delegation Oversight.

b. CalOptima shall monitor healthcare service utilization and outcomes of member populations receiving CalOptima Community Supports as follows:

i. On a monthly basis, CalOptima shall monitor the housing status and program participation for each Member receiving housing-related CalOptima Community Supports.

ii. On a semi-annual basis, CalOptima shall monitor emergency room visits and hospitalizations for Members receiving Recuperative Care and analyze utilization prior to and after initiation of services.

N. CalOptima shall submit the following data and reports in a manner, format and frequency as defined by DHCS:

1. Encounter data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS, including services generated under subcontracting arrangements.

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2. Data will be provided to:

   a. Evaluate the utilization and effectiveness of a Community Support;

   b. Monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken; and

   c. Monitor Member appeals and grievances associated with Community Supports.

3. Supplemental reports, on a schedule and in a format as specified by DHCS.

IV. ATTACHMENT(S)

A. Community Supports Components
B. Community Supports Eligibility (Population Subset)

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
B. Department of Health Care Services (DHCS) Managed Care Plan ECM and ILOS Contract Template
C. CalAIM ECM and Community Supports Model of Care Template
D. Medi-Cal Community Supports Policy Guide (December 2021)
E. CalOptima Contract for Health Care Services
F. CalOptima Policy DD.2002: Cultural and Linguistic Services
G. CalOptima Policy EE.1103Δ: Provider Education and Training
H. CalOptima Policy EE.1141Δ: CalOptima Provider Contracts
I. CalOptima Policy FF.2001: Claims Processing for Covered Services which CalOptima is Financially Responsible
J. CalOptima Policy GG.1353: Enhanced Care Management (ECM) Service Delivery
K. CalOptima Policy GG.1356: Enhanced Care Management (ECM) Administration
L. CalOptima Policy GG.1500 Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
M. CalOptima Policy GG.1507: Notification Requirements for Covered Services Requiring Prior Authorization.
N. CalOptima Policy GG.1508 Authorization and Processing of Referrals
O. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners and
P. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
Q. CalOptima Policy HH.1101: CalOptima Provider Complaint
R. CalOptima Policy HH.1102: Member Grievance
S. CalOptima Policy HH.1104: Complaints of Discrimination
T. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
U. CalOptima Policy HH.2021Δ: Exclusion and Preclusion Monitoring
V. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response

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11/30/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1355	Community Supports	Medi-Cal
Revised	TBD	GG.1355	Community Supports	Medi-Cal

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IX. GLOSSARY

Term	Definition
Appeal	A review by CalOptima of an adverse benefit determination, which includes one of the following actions: 1. A denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a Covered Service; 2. A reduction, suspension, or termination of a previously authorized service; 3. A denial, in whole or in part, of payment for a service; 4. Failure to provide services in a timely manner; or 5. Failure to act within the timeframes provided in 42 CFR 438.408(b).
California Medicaid State Plan	A comprehensive description of California's State Medicaid Program, based upon the requirements of Title XIX of the Social Security Act, that serves as a contractual agreement between the State of California and the federal Centers for Medicare and Medicaid Services.
CalOptima Community Supports	Community Supports that CalOptima has received approval from the Department of Health Care Services (DHCS) to provide.
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of the DHCS-approved CalOptima Community Supports. Providers are entities with experience and expertise providing one (1) or more of the CalOptima Community Supports approved by the DHCS.

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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, 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 Enhanced Care Management and CalOptima Community Supports (as provided under the California Advancing and Innovating Medi-Cal initiative) for Members meeting eligibility criteria, 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.
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
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.
ECM Provider	A Provider within the community that has a contractual relationship with CalOptima (such as a delegated Health Network) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
Encounter	Any unit of Covered Services provided to a member by a Health Network regardless of reimbursement methodology.
Grievance	An oral or written expression of dissatisfaction about any matter other than an action that is an adverse benefit determination, as identified within the definition of an Appeal, and may include, but is not limited to: the quality of care or services provided, interpersonal relationships with a Provider or CalOptima's employee, failure to respect a Member's rights regardless of whether remedial action is requested, and the right to dispute an extension of time proposed by CalOptima to make an authorization decision.
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.

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Term	Definition
Medically Necessary or Medical Necessity	Reasonable and necessary Covered Services to protect life, to prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness, or injury, as required under W&I Code 14059.5(a) and Title 22 CCR Section 51303(a). Medically Necessary services shall include Covered Services necessary to achieve age-appropriate growth and development, and attain, maintain, or regain functional capacity. For Members under 21 years of age, a service is Medically Necessary if it meets the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of medical necessity set forth in Section 1396d(r)(5) of Title 42 of the United States Code, as required by W&I Code 14059.5(b) and W&I Code Section 14132(v). Without limitation, Medically Necessary services for Members under 21 years of age include Covered Services necessary to achieve or maintain age-appropriate growth and development, attain, regain or maintain functional capacity, or improve, support or maintain the Member's current health condition. CalOptima shall determine Medical Necessity on a case-by-case basis, taking into account the individual needs of the child.
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.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Recuperative Care	Short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

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I. Housing Transition Navigation Services

A. Service Description: Housing Transition Navigation Services assist Members with obtaining housing and include the following components:

1. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and on potential housing transition barriers, as well as identification of housing retention barriers.

2. Development of an individualized housing support plan, that:

   a. Is based upon the housing assessment;

   b. Addresses identified barriers;

   c. Includes measurable short- and long-term goals for each issue;

      i. Establishes the Member's approach to meeting the goal; and

      ii. Identifies other providers or services required to meet the goal, whether reimbursed by Medi-Cal or not.

3. Searching for housing and presenting options to the Member.

4. Assisting in securing housing as documented in the individualized housing support plan.

5. Completion of housing applications.

6. Securing required documentation:

   a. Social Security card;

   b. Birth certificate; and

   c. Prior rental history.

7. Assisting with benefits advocacy as documented in the individualized housing support plan, such as, but not limited to:

   a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

   b. Supporting SSI application process, as appropriate.

8. Identifying and securing available resources to subsidize rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program (Section 8), or State

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and local assistance programs) and matching available rental subsidy resources to Members, as documented in the individualized housing support plan.

a. Identifying and securing resources to cover expenses identified in the individualized housing support plan, such as, but not limited to:

i. Security deposit;

ii. Moving costs;

iii. Adaptive aids;

iv. Environmental modifications; and

v. Other one-time expenses.

9. Assisting with requests for reasonable accommodation, if necessary, as documented in the individualized housing support plan.

10. Educating and engaging with landlords.

a. Ensuring that the living environment is safe and ready for move-in;

b. Communicating and advocating on behalf of the Member with landlords; and

c. Assisting with arranging for and supporting the details of the move.

11. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan, that includes prevention and early intervention services when housing is jeopardized.

12. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day, as documented in the individualized housing support plan.

13. Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptation Community Supports), as documented in the individualized housing support plan.

B. Restrictions/Limitations:

1. Housing Transition/ Navigation Services must be identified as reasonable and necessary in the Member's individualized housing support plan. Service duration can be as long as necessary.

2. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~through other State ~~or~~, local ~~tax~~, or federally ~~-~~ funded programs, ~~which shall be considered first, before using Medi-Cal funding~~in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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II. Housing Deposits

A. Service Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board or payment of rental costs, including, but not limited to:

1. Security deposits required to obtain a lease on an apartment or home.

2. Set-up fees/deposits for utilities or service access and utility arrearages.

3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

4. First and last month's rent as required by landlord for occupancy.

5. Services necessary for the Member's health and safety such as pest eradication and one-time cleaning prior to occupancy.

6. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve a Member's health and safety in the home such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. Restrictions/Limitations

1. Housing Deposits are available once in an individual's lifetime.

   a. Housing Deposits can only be approved ***one additional*** time with documentation as to what has changed to demonstrate that a second Housing Deposit would be more successful on the second attempt.

   b. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. The individualized housing support plan must identify the Housing Deposit as reasonable and necessary, and that the Member is otherwise unable to meet this expense.

3. A Member must also be receiving Housing Transition Navigation Services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service.

4. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~through other State, local, or federally-~~-~~funded programs, ~~which shall be considered first, before using Medi-Cal funding.~~in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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III. Housing Tenancy and Sustaining Services

A. Service Description: Housing Tenancy and Sustaining Services provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include the following, based on an individualized assessment of needs and documented in the individualized housing support plan:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2. Education and training on the roles, rights, and responsibilities of the tenant and landlord.

3. Coaching on developing and maintaining key relationships with landlords/property managers to foster successful tenancy.

4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

5. Assistance in resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse action.

    a. Includes development of a repayment plan and/or identifying funding in the case where a Member owes back rent or payment for damage to a unit.

6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

7. Assisting with benefits advocacy, including:

    a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

    b. Supporting SSI application process, as appropriate.

8. Assistance with the annual housing recertification process.

9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and addressing existing or recurring housing retention barriers.

10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

11. Health and safety visits, including unit habitability inspections.

12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

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13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

B. Restrictions/Limitations:

1. Housing Tenancy and Sustaining Services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are available for a single duration in a Member's lifetime.

a. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing these services would be more successful on the second attempt.

b. CalOptima or a Health Network, as appliable, shall make a good faith effort to review information available to them to determine whether the Member has previously received services.

c. Service duration can be as long as necessary.

2. Housing Tenancy and Support Services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to successfully maintain longer-term housing without such assistance.

3. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~through other State, local, or federally-~~-~~funded programs, ~~which shall be considered first, before using Medi-Cal funding~~in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IV. Recuperative Care (Medical Respite)

A. Service Description: Recuperative Care is short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment. Recuperative Care will be provided for a duration not to exceed 90 continuous days in duration and will include, at a minimum:

1. Interim housing with a bed and meals.

2. Ongoing monitoring of a Member's ongoing medical or behavioral health condition, such as, but not limited to:

a. Vital signs;

b. Assessments;

c. Wound care; and

d. Medication monitoring.

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3. Based on individual needs, the service may also include:

   a. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs);

   b. Coordination of transportation to post-discharge appointments;

   c. Connection to any other ongoing services a Member may require, including mental health and substance use disorder services;

   d. Support in accessing benefits and housing; and

   e. Gaining stability with case management relationships and programs.

B. Restrictions/Limitations:

1. Recuperative Care is an allowable Community Supports if it:

   a. Is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions;

   b. Is not more than 90 days in continuous duration; and

   c. Does not include funding for building modification or building rehabilitation.

2. Community Supports shall supplement and not supplant services received by the Members ~~may not be receiving duplicative support from~~ through other State, local, or federally~~-~~-funded programs, ~~which shall~~ in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. Short-Term Post-Hospitalization Housing

A. Service Description: Short-Term Post-Hospitalization provides temporary housing for Members to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital or facility, and provide ongoing supports necessary for recuperation and recovery that may include, but not limited to:

1. Assistance with gaining/regaining ability to perform activities of daily living.

2. Receiving necessary medical/psychiatric/substance use disorder care.

3. Receiving case management services.

4. Assistance with accessing other housing supports such as Housing Transition Navigation.

5. Housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.

B. Restrictions/Limitations

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1. Short-Term Post-Hospitalization services are available once in an individual's lifetime and not to exceed a duration of six (6) months.

   a. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VI. Medically Tailored Meals/Medically-Supportive Food

A. Service Description: Medically Tailored Meals/Medically-Supportive Food provides meals that help Members achieve their nutrition goals at critical times to regain and maintain their health and provide services that may include, but not limited to:

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

2. Medically-Tailored Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.

3. Medically-Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

B. Restrictions/Limitations

1. Medically-tailored meals are:

   a. Provided up to two (2) meals per day; and/or

   b. Medically-supportive food and nutrition services provided for up to 12 weeks or longer if medically necessary.

2. Meals that are eligible for or reimbursed by alternate programs are not eligible.

3. Meals are not covered to respond solely to food insecurities.

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4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VII. Sobering Centers

A. Service Description: Sobering Centers provides an alternative destination for Members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Services may include, but not limited to:

1. Medical Services

    a. Medical triage;

    b. Lab testing;

    c. Treatment for nausea; and

    d. Wound and dressing changes;

2. Personal and Hygiene Care Services

    a. Temporary bed;

    b. Rehydration and food service; and

    c. Shower and laundry facilities;

3. Substance use education and counseling.

4. Navigation and warm hand-offs for additional substance use services.

5. Direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services.

6. Screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.

7. Establishing strong partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.

8. Identifying Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.

9. Utilizing best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

10. Other necessary health care services and homeless care support services as appropriate.

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B. Restrictions/Limitations

1. Sobering Center service is covered for a duration of less than twenty-four (24) hours.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VIII. Personal Care and Homemaker Services

A. Service Description: Personal Care and Homemaker Services provide Members who need assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs) the ability to remain in their home/residence. Services may include but not limited to:

1. ADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management.

2. IADLs such as cleaning, meal preparation, grocery shopping, and money management.

B. Restrictions/Limitations

1. Personal Care and Homemaker Services cannot be ~~considered first, before using~~utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

2. If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

3. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IX. Day Habilitation

A. Service Description: Day Habilitation Programs provide assistance to Members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Services are provided in a Member's home or an out-of-home, non- facility setting with an unlicensed caregiver with the necessary training and supervision.

1. Day Habilitation Program services include, but are not limited to, training on:

a. The use of public transportation;

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b. Personal skills development in conflict resolution;

c. Community participation;

d. Developing and maintaining interpersonal relationships;

e. Daily living skills (cooking, cleaning, shopping, money management); and

f. Community resource awareness such as police, fire, or local services to support independence in the community.

2. Other program services may include assistance with, but not limited to, the following:

a. Selecting and moving into a home;

b. Locating and choosing suitable housemates;

c. Locating household furnishings;

d. Settling disputes with landlords;

e. Managing personal financial affairs;

f. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

g. Dealing with and responding appropriately to governmental agencies and personnel;

h. Asserting civil and statutory rights through self-advocacy;

i. Building and maintaining interpersonal relationships, including a circle of support;

j. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;

k. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Serv ices Community Support eligibility criteria;

l. Assistance with income and benefits advocacy including General assistance/General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and/or

m. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or enhanced care management.

B. Restrictions/Limitations

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1. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

X. Respite Services

A. Service Description: Respite services are provided to caregivers of Members who require intermittent temporary supervision. These services are provided on a short-term basis because of the absence or need for relief of the caregiver who normally care for and/or supervise the Member and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Respite services can include any of the following that may include, but not limited to:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

4. Services are provided in:

   a. Private residence;

   b. Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs); or

   c. Providers contracted by county behavioral health.

B. Restrictions/Limitations

1. In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed twenty-four (24) hours per day of care.

2. Service limit is up to three hundred thirty-six (336) hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the three hundred thirty-six (336) hour per calendar year limit can be made, with CalOptima or Health Network authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Member without their caregiver. Respite support provided during these episodes can be excluded from the three hundred thirty-six (336)-hour annual limit.

3. Respite service is only to avoid placements for which the CalOptima or a Health Network would be responsible.

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4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XI. Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care)

A. Service Description: Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care) helps Members who would like to transition back into a home-like, community setting and/or to avoid institutionalization when possible. Members have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. These services may include, but not limited to:

1. Wrap-around Services:

   a. Assistance with ADLs and IADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management as needed;

   b. IIADLs such as cleaning, meal preparation, grocery shopping, and money management as needed;

   c. Companion services;

   d. Medication oversight;

   e. Therapeutic social and recreational programming provided in a home-like environment; and

   f. Includes twenty-four (24)-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

2. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

   a. Assessing the Member's housing needs and presenting options;

   b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF) so the Member can be safely and stably housed in an RCFE/ARF;

   c. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

   d. Communicating with facility administration and coordinating the move;

   e. Establishing procedures and contacts to retain facility housing; and

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f. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

i. Managed care plans my also fund RCFE/ARF operations directly to provide these enhanced services.

B. Restrictions/Limitations

1. Members are directly responsible for paying their own living expenses.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XII. Community Transition Services/Nursing Facility Transition to a Home

A. Service Description: Community Transition Services/Nursing Facility Transition to a Home Services provide assistance to Members to live in the community and avoid further institutionalization. Members are transitioning from a licensed facility to a living arrangement in a private residence are directly responsible for his or her own living expenses. Services may include, but not limited to:

1. Allowable expenses necessary to enable a person to establish a basic household that do not constitute room and board and include:

a. Assessing the Member's housing needs and presenting options;

b. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

c. Communicating with landlord (if applicable) and coordinating the move;

d. Establishing procedures and contacts to retain housing;

e. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day; and

f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

B. Restrictions/Limitations

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1. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

2. Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

3. Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIII. Environmental Accessibility Adaptations (Home Modifications)

A. Service Description: Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization. These services may include, but not limited to:

1. In-home modifications such as:

a. Ramps and grab-bars to assist Members in accessing the home;

b. Doorway widening for Members who require a wheelchair;

c. Stair lifts;

d. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);

e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

f. Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

B. Restrictions/Limitations

1. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

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2. EAAs must be conducted in accordance with applicable State and local building codes.

3. EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIV. Asthma Remediation

A. Service Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Services may include, but not limited to:

1. Providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

   a. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

2. Purchasing materials such as:

   a. Allergen-impermeable mattress and pillow dustcovers;

   b. High-efficiency particulate air (HEPA) filtered vacuums;

   c. Asthma friendly cleaning products;

   d. De-humidifiers; and

   e. Air filters;

3. Health-related minor home repairs such as:

   a. Pest management or patching holes and cracks through which pests can enter;

   b. Minor mold removal and remediation services;

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c. Ventilation improvements;

d. Integrated Pest Management (IPM) services; and

e. Other moisture-controlling interventions;

4. Other interventions identified to be medically appropriate and cost effective.

B. Restrictions/Limitations

1. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

2. Asthma remediations must be conducted in accordance with applicable State and local building codes.

3. Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

~~1.~~5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. References

A. Department of Health Care Services Medi-Cal ~~In Lieu of Services (ILOS)~~Community Supports Policy Guide (~~September~~December 2021), Section III. ~~In Lieu of Services~~Community Supports – Service Definitions includes comprehensive service descriptions and restrictions/limitations of Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Description/Overview and Restrictions/Limitations sections.

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I. Housing Transition Navigation Services

A. Service Description: Housing Transition Navigation Services assist Members with obtaining housing and include the following components:

1. Conducting a tenant screening and housing assessment that identifies the Member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the Member's housing needs and on potential housing transition barriers, as well as identification of housing retention barriers.

2. Development of an individualized housing support plan, that:

   a. Is based upon the housing assessment;

   b. Addresses identified barriers;

   c. Includes measurable short- and long-term goals for each issue;

      i. Establishes the Member's approach to meeting the goal; and

      ii. Identifies other providers or services required to meet the goal, whether reimbursed by Medi-Cal or not.

3. Searching for housing and presenting options to the Member.

4. Assisting in securing housing as documented in the individualized housing support plan.

5. Completion of housing applications.

6. Securing required documentation:

   a. Social Security card;

   b. Birth certificate; and

   c. Prior rental history.

7. Assisting with benefits advocacy as documented in the individualized housing support plan, such as, but not limited to:

   a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

   b. Supporting SSI application process, as appropriate.

8. Identifying and securing available resources to subsidize rent (such as U.S. Department of Housing and Urban Development's Housing Choice Voucher Program (Section 8), or State and local assistance programs) and matching available rental subsidy resources to Members, as documented in the individualized housing support plan.

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a. Identifying and securing resources to cover expenses identified in the individualized housing support plan, such as, but not limited to:

i. Security deposit;

ii. Moving costs;

iii. Adaptive aids;

iv. Environmental modifications; and

v. Other one-time expenses.

9. Assisting with requests for reasonable accommodation, if necessary, as documented in the individualized housing support plan.

10. Educating and engaging with landlords.

a. Ensuring that the living environment is safe and ready for move-in;

b. Communicating and advocating on behalf of the Member with landlords; and

c. Assisting with arranging for and supporting the details of the move.

11. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan, that includes prevention and early intervention services when housing is jeopardized.

12. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day, as documented in the individualized housing support plan.

13. Identifying and coordinating environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptation Community Supports), as documented in the individualized housing support plan.

B. Restrictions/Limitations:

1. Housing Transition/ Navigation Services must be identified as reasonable and necessary in the Member's individualized housing support plan. Service duration can be as long as necessary.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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II. Housing Deposits

A. Service Description: Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board or payment of rental costs, including, but not limited to:

1. Security deposits required to obtain a lease on an apartment or home.

2. Set-up fees/deposits for utilities or service access and utility arrearages.

3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.

4. First and last month's rent as required by landlord for occupancy.

5. Services necessary for the Member's health and safety such as pest eradication and one-time cleaning prior to occupancy.

6. Goods such as an air conditioner or heater, and other medically necessary adaptive aids and services, designed to preserve a Member's health and safety in the home such as hospital beds, Hoyer lifts, air filters, and specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the Member upon move-in to the home.

B. Restrictions/Limitations

1. Housing Deposits are available once in an individual's lifetime.

   a. Housing Deposits can only be approved ***one additional*** time with documentation as to what has changed to demonstrate that a second Housing Deposit would be more successful on the second attempt.

   b. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. The individualized housing support plan must identify the Housing Deposit as reasonable and necessary, and that the Member is otherwise unable to meet this expense.

3. A Member must also be receiving Housing Transition Navigation Services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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III. Housing Tenancy and Sustaining Services

A. Service Description: Housing Tenancy and Sustaining Services provide tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured. Services include the following, based on an individualized assessment of needs and documented in the individualized housing support plan:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.

2. Education and training on the roles, rights, and responsibilities of the tenant and landlord.

3. Coaching on developing and maintaining key relationships with landlords/property managers to foster successful tenancy.

4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.

5. Assistance in resolving disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse action.

    a. Includes development of a repayment plan and/or identifying funding in the case where a Member owes back rent or payment for damage to a unit.

6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.

7. Assisting with benefits advocacy, including:

    a. Assisting in obtaining and submitting necessary documentation for SSI eligibility, as appropriate; and

    b. Supporting SSI application process, as appropriate.

8. Assistance with the annual housing recertification process.

9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and addressing existing or recurring housing retention barriers.

10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.

11. Health and safety visits, including unit habitability inspections.

12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

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13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

B. Restrictions/Limitations:

1. Housing Tenancy and Sustaining Services are available from the initiation of services through the time when the Member's housing support plan determines they are no longer needed. They are available for a single duration in a Member's lifetime.

a. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing these services would be more successful on the second attempt.

b. CalOptima or a Health Network, as appliable, shall make a good faith effort to review information available to them to determine whether the Member has previously received services.

c. Service duration can be as long as necessary.

2. Housing Tenancy and Support Services must be identified as reasonable and necessary in the Member's individualized housing support plan and are available only when the Member is unable to successfully maintain longer-term housing without such assistance.

3. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IV. Recuperative Care (Medical Respite)

A. Service Description: Recuperative Care is short-term residential care for individuals who do not require hospitalization but need to recover from a physical or behavioral health injury or illness and whose condition would be exacerbated by an unstable living environment. Recuperative Care will be provided for a duration not to exceed 90 continuous days in duration and will include, at a minimum:

1. Interim housing with a bed and meals.

2. Ongoing monitoring of a Member's ongoing medical or behavioral health condition, such as, but not limited to:

a. Vital signs;

b. Assessments;

c. Wound care; and

d. Medication monitoring.

3. Based on individual needs, the service may also include:

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a. Limited or short-term assistance with Instrumental Activities of Daily Living (IADLs) and/or Activities of Daily Living (ADLs);

b. Coordination of transportation to post-discharge appointments;

c. Connection to any other ongoing services a Member may require, including mental health and substance use disorder services;

d. Support in accessing benefits and housing; and

e. Gaining stability with case management relationships and programs.

B. Restrictions/Limitations:

1. Recuperative Care is an allowable Community Supports if it:

a. Is necessary to achieve or maintain medical stability and prevent hospital admission or readmission, which may require behavioral health interventions;

b. Is not more than 90 days in continuous duration; and

c. Does not include funding for building modification or building rehabilitation.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. Short-Term Post-Hospitalization Housing

A. Service Description: Short-Term Post-Hospitalization provides temporary housing for Members to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital or facility, and provide ongoing supports necessary for recuperation and recovery that may include, but not limited to:

1. Assistance with gaining/regaining ability to perform activities of daily living.

2. Receiving necessary medical/psychiatric/substance use disorder care.

3. Receiving case management services.

4. Assistance with accessing other housing supports such as Housing Transition Navigation.

5. Housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.

B. Restrictions/Limitations

1. Short-Term Post-Hospitalization services are available once in an individual's lifetime and not to exceed a duration of six (6) months.

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a. A good faith effort must be made by CalOptima or the Health Network to determine whether a Member has previously received services.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VI. Medically Tailored Meals/Medically-Supportive Food

A. Service Description: Medically Tailored Meals/Medically-Supportive Food provides meals that help Members achieve their nutrition goals at critical times to regain and maintain their health and provide services that may include, but not limited to:

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.

2. Medically-Tailored Meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.

3. Medically-Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.

5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

B. Restrictions/Limitations

1. Medically-tailored meals are:

a. Provided up to two (2) meals per day; and/or

b. Medically-supportive food and nutrition services provided for up to 12 weeks or longer if medically necessary.

2. Meals that are eligible for or reimbursed by alternate programs are not eligible.

3. Meals are not covered to respond solely to food insecurities.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VII. Sobering Centers

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A. Service Description: Sobering Centers provides an alternative destination for Members, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober. Services may include, but not limited to:

1. Medical Services
    a. Medical triage;
    b. Lab testing;
    c. Treatment for nausea; and
    d. Wound and dressing changes;
2. Personal and Hygiene Care Services
    a. Temporary bed;
    b. Rehydration and food service; and
    c. Shower and laundry facilities;
3. Substance use education and counseling.
4. Navigation and warm hand-offs for additional substance use services.
5. Direct coordination with the county behavioral health agency and warm hand-offs for additional behavioral health services.
6. Screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
7. Establishing strong partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers.
8. Identifying Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
9. Utilizing best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.
10. Other necessary health care services and homeless care support services as appropriate.

B. Restrictions/Limitations

1. Sobering Center service is covered for a duration of less than twenty-four (24) hours.

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2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

VIII. Personal Care and Homemaker Services

A. Service Description: Personal Care and Homemaker Services provide Members who need assistance with Activities of Daily Living (ADLs) and/or Instrumental Activities of Daily Living (IADLs) the ability to remain in their home/residence. Services may include but not limited to:

1. ADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management.

2. IADLs such as cleaning, meal preparation, grocery shopping, and money management.

B. Restrictions/Limitations

1. Personal Care and Homemaker Services cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

2. If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

3. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

IX. Day Habilitation

A. Service Description: Day Habilitation Programs provide assistance to Members in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. Services are provided in a Member's home or an out-of-home, non- facility setting with an unlicensed caregiver with the necessary training and supervision.

1. Day Habilitation Program services include, but are not limited to, training on:

   a. The use of public transportation;

   b. Personal skills development in conflict resolution;

   c. Community participation;

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d. Developing and maintaining interpersonal relationships;

e. Daily living skills (cooking, cleaning, shopping, money management); and

f. Community resource awareness such as police, fire, or local services to support independence in the community.

2. Other program services may include assistance with, but not limited to, the following:

a. Selecting and moving into a home;

b. Locating and choosing suitable housemates;

c. Locating household furnishings;

d. Settling disputes with landlords;

e. Managing personal financial affairs;

f. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;

g. Dealing with and responding appropriately to governmental agencies and personnel;

h. Asserting civil and statutory rights through self-advocacy;

i. Building and maintaining interpersonal relationships, including a circle of support;

j. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;

k. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Serv ices Community Support eligibility criteria;

l. Assistance with income and benefits advocacy including General assistance/General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and/or

m. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or enhanced care management.

B. Restrictions/Limitations

1. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

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X. Respite Services

A. Service Description: Respite services are provided to caregivers of Members who require intermittent temporary supervision. These services are provided on a short-term basis because of the absence or need for relief of the caregiver who normally care for and/or supervise the Member and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only. Respite services can include any of the following that may include, but not limited to:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.

2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.

3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

4. Services are provided in:

   a. Private residence;

   b. Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs); or

   c. Providers contracted by county behavioral health.

B. Restrictions/Limitations

1. In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed twenty-four (24) hours per day of care.

2. Service limit is up to three hundred thirty-six (336) hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the three hundred thirty-six (336) hour per calendar year limit can be made, with CalOptima or Health Network authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Member without their caregiver. Respite support provided during these episodes can be excluded from the three hundred thirty-six (336)-hour annual limit.

3. Respite service is only to avoid placements for which the CalOptima or a Health Network would be responsible.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XI. Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care)

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A. Service Description: Nursing Facility Transition/Diversion to Assisted Living Facilities (Residential Care) helps Members who would like to transition back into a home-like, community setting and/or to avoid institutionalization when possible. Members have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements. These services may include, but not limited to:

1. Wrap-around Services:

   a. Assistance with ADLs and IADLs such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with such as meal preparation, grocery shopping, and money management as needed;

   b. IIADLs such as cleaning, meal preparation, grocery shopping, and money management as needed;

   c. Companion services;

   d. Medication oversight;

   e. Therapeutic social and recreational programming provided in a home-like environment; and

   f. Includes twenty-four (24)-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security.

2. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

   a. Assessing the Member's housing needs and presenting options;

   b. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF) so the Member can be safely and stably housed in an RCFE/ARF;

   c. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

   d. Communicating with facility administration and coordinating the move;

   e. Establishing procedures and contacts to retain facility housing; and

   f. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.

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i. Managed care plans my also fund RCFE/ARF operations directly to provide these enhanced services.

B. Restrictions/Limitations

1. Members are directly responsible for paying their own living expenses.

2. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XII. Community Transition Services/Nursing Facility Transition to a Home

A. Service Description: Community Transition Services/Nursing Facility Transition to a Home Services provide assistance to Members to live in the community and avoid further institutionalization. Members are transitioning from a licensed facility to a living arrangement in a private residence are directly responsible for his or her own living expenses. Services may include, but not limited to:

1. Allowable expenses necessary to enable a person to establish a basic household that do not constitute room and board and include:

a. Assessing the Member's housing needs and presenting options;

b. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history);

c. Communicating with landlord (if applicable) and coordinating the move;

d. Establishing procedures and contacts to retain housing;

e. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day; and

f. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.

B. Restrictions/Limitations

1. Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.

2. Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is

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compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.

3. Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

4. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIII. Environmental Accessibility Adaptations (Home Modifications)

A. Service Description: Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization. These services may include, but not limited to:

1. In-home modifications such as:

   a. Ramps and grab-bars to assist Members in accessing the home;

   b. Doorway widening for Members who require a wheelchair;

   c. Stair lifts;

   d. Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower);

   e. Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and

   f. Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

B. Restrictions/Limitations

1. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.

2. EAAs must be conducted in accordance with applicable State and local building codes.

3. EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the

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Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

XIV. Asthma Remediation

A. Service Description: Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization. Services may include, but not limited to:

1. Providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

   a. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

2. Purchasing materials such as:

   a. Allergen-impermeable mattress and pillow dustcovers;

   b. High-efficiency particulate air (HEPA) filtered vacuums;

   c. Asthma friendly cleaning products;

   d. De-humidifiers; and

   e. Air filters;

3. Health-related minor home repairs such as:

   a. Pest management or patching holes and cracks through which pests can enter;

   b. Minor mold removal and remediation services;

   c. Ventilation improvements;

   d. Integrated Pest Management (IPM) services; and

   e. Other moisture-controlling interventions;

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4. Other interventions identified to be medically appropriate and cost effective.

B. Restrictions/Limitations

1. If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

2. Asthma remediations must be conducted in accordance with applicable State and local building codes.

3. Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

4. Asthma Remediation modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

5. Community Supports shall supplement and not supplant services received by the Members through other State, local, or federally-funded programs, in accordance with the CalAIM Special Terms and Conditions and federal and DHCS guidance.

V. References

A. Department of Health Care Services Medi-Cal Community Supports Policy Guide (December 2021), Section III. Community Supports – Service Definitions includes comprehensive service descriptions and restrictions/limitations of Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Description/Overview and Restrictions/Limitations sections.

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I. Eligibility for Housing Transition Navigation Services

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

B. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

C. Members who meet the HUD definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation Services if they have significant barriers to housing stability and meet one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

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II. Eligibility for Housing Deposits

A. Any Member who received Housing Transition/Navigation Services Community Supports; and

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder.

III. Eligibility for Housing Tenancy and Sustaining Services

A. Any Member who received Housing Transition/Navigation Services Community Supports; or

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet one of the following:

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a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

IV. Eligibility for Recuperative Care (Medical Respite)

A. Members who are at risk of hospitalization or are post-hospitalization, and

1. Live alone with no formal supports; or

2. Face housing insecurity, or

3. Have housing that would jeopardize their health and safety without modification.

V. Eligibility for Short-Term Hospitalization Housing

A. Members who are exiting recuperative care; or

B. Members exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility with a medical and or behavioral health need; and

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

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D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. An individual or family who:

a. Has an annual income below thirty percent (30%) of median family income for the area, as determined by HUD;

b. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place; and

c. Meets one of the following conditions:

i. Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;

ii. Is living in the home of another because of economic hardship;

iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within twenty-one (21) days after the date of application for assistance;

d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organization or by federal, State, or local government programs for low-income individuals;

e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two (2) persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

f. Is exiting a publicly-funded institution, or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

2. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

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3. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardians of that child or youth if living with her or him.

E. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability and meet at least one of the following:

1. Have one or more serious chronic conditions;

2. Have a Serious Mental Illness;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

4. Are receiving Enhanced Care Management; or

5. Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

F. In addition to meeting one of these criteria at a minimum, Members must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re- hospitalization, or institutional readmission.

VI. Eligibility for Medically-Tailored Meals

A. Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

B. Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

C. Members with extensive care coordination needs.

VII. Eligibility for Sobering Centers

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A. Members age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms); and

B. Members who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

VIII. Eligibility for Personal Care/Homemaker services

A. Members at risk for hospitalization, or institutionalization in a nursing facility;

B. Members with functional deficits and no other adequate support system; or

C. Members approved for In-Home Supportive Services.

IX. Eligibility for Day Habilitation Program

A. Members who are experiencing homelessness,

B. Members who exited homelessness and entered housing in the last twenty-four (24) months; and

C. Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

X. Eligibility for Respite Services

A. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support; and

B. Members who require caregiver relief to avoid institutional placement; or

C. Members may include children who previously were covered for Respite Services under the:

1. Pediatrics Palliative Care Waiver;

2. Foster care program beneficiaries;

3. California Children's Services;

4. Genetically Handicapped Persons Program (GHPP); or

5. Members with Complex Care Needs.

XI. Eligibility for Nursing Facility Transition for Elderly and Adult Residential Facilities

A. For Nursing Facility Transition:

1. Member has resided 60+ days in a nursing facility;

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2. Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3. Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:

1. Member is interested in remaining in the community;

2. Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3. Member must be:

a. Currently receiving medically necessary nursing facility Level of Care (LOC) services; and

b. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

XII. Eligibility for Community Transition Services/Nursing Facility Transition to Home

A. Member must be:

1. Currently receiving medically necessary nursing facility Level of Care (LOC) services and;

2. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

B. Member has lived 60+ days in a nursing home and/or Medical Respite setting; and

C. Member is interested in moving back to the community; and

D. Member is able to reside safely in the community with appropriate and cost-effective supports and services.

XIII. Eligibility for Environmental Accessibility Adaptions

A. Member is at risk for institutionalization in a nursing facility.

XIV. Eligibility for Asthma Remediation

A. Members with poorly controlled asthma as determined by:

1. An emergency department visit or hospitalization; or

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2. Two (2) sick or urgent care visits in the past twelve (12) months; or

3. A score of 19 or lower on the Asthma Control Test, and

4. A licensed health care provider who has documentation that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

~~V.~~XV. Restrictions/Limitations References

Restrictions and/or limitations for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite~~)~~, Short-Term Hospitalization Housing, Medically-Tailored Meals, Sobering Centers, Personal Care/Homemaker services, Day Habilitation Program, Respite Services, Nursing Facility Transition for Elderly and Adult Residential Facilities, Community Transition Services/Nursing Facility Transition to Home, Environmental Accessibility Adaptions and Asthma Remediation are set forth in Attachment A: Community Supports Components of CalOptima Policy GG.1355.

~~VI.~~XVI. References

A. Department of Health Care Services Medi-Cal ~~In Lieu of Services (ILOS)~~Community Supports Policy Guide (~~September~~December 2021), Section III. ~~In Lieu of Services~~Community Supports – Service Definitions includes comprehensive Member eligibility criteria for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Eligibility (Population Subset) sections.

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VII. Glossary

Term	Definition
Coordinated Entry System	A process which coordinates the assessment and referral of individuals and families seeking housing and includes the use of a comprehensive and standardized assessment tool. In Orange County, it includes the Family Coordinated Entry System and the Individual Coordinated Entry System.
Homeless Management Information Systems (HMIS)	A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness and is compliant with HUD's data collection, management, and reporting standards.
United States Department of Housing and Urban Development (HUD)	The Federal agency responsible for national policy and programs that address national housing needs, improve and develop communities, and enforce fair housing laws.

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I. Eligibility for Housing Transition Navigation Services

A. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

B. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

C. Members who meet the HUD definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation Services if they have significant barriers to housing stability and meet one of the following:

a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

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II. Eligibility for Housing Deposits

A. Any Member who received Housing Transition/Navigation Services Community Supports; and

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder.

III. Eligibility for Housing Tenancy and Sustaining Services

A. Any Member who received Housing Transition/Navigation Services Community Supports; or

B. Members who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system; or

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR section 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. Members who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining Services if they have significant barriers to housing stability and meet one of the following:

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a. Have one or more serious chronic conditions;

b. Have a serious mental illness;

c. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder;

d. Have a serious emotional disturbance (children and adolescents);

e. Are receiving Enhanced Care Management; or

f. Are a transition-age youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or are children or adolescents with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

IV. Eligibility for Recuperative Care (Medical Respite)

A. Members who are at risk of hospitalization or are post-hospitalization, and

1. Live alone with no formal supports; or

2. Face housing insecurity, or

3. Have housing that would jeopardize their health and safety without modification.

V. Eligibility for Short-Term Hospitalization Housing

A. Members who are exiting recuperative care; or

B. Members exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility with a medical and or behavioral health need; and

C. Members who meet the Housing and Urban Development (HUD) definition of homeless as defined in 24 CFR § 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) and meet one of the following criteria:

1. Are receiving Enhanced Care Management; and/or

2. Have one or more serious chronic conditions; and/or

3. Have a serious mental illness; and/or

4. Are at risk of institutionalization or requiring residential services because of a substance use disorder; or

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D. Members who meet the Housing and Urban Development (HUD) definition of at risk of homelessness (as defined in 24 CFR § 91.5).

1. An individual or family who:

a. Has an annual income below thirty percent (30%) of median family income for the area, as determined by HUD;

b. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place; and

c. Meets one of the following conditions:

i. Has moved because of economic reasons two or more times during the sixty (60) days immediately preceding the application for homelessness prevention assistance;

ii. Is living in the home of another because of economic hardship;

iii. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within twenty-one (21) days after the date of application for assistance;

d. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organization or by federal, State, or local government programs for low-income individuals;

e. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two (2) persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

f. Is exiting a publicly-funded institution, or system of care (such as a health care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan.

2. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

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3. A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardians of that child or youth if living with her or him.

E. Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability and meet at least one of the following:

1. Have one or more serious chronic conditions;

2. Have a Serious Mental Illness;

3. Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

4. Are receiving Enhanced Care Management; or

5. Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

F. In addition to meeting one of these criteria at a minimum, Members must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re- hospitalization, or institutional readmission.

VI. Eligibility for Medically-Tailored Meals

A. Members with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.

B. Members being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or

C. Members with extensive care coordination needs.

VII. Eligibility for Sobering Centers

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A. Members age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms); and

B. Members who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

VIII. Eligibility for Personal Care/Homemaker services

A. Members at risk for hospitalization, or institutionalization in a nursing facility;

B. Members with functional deficits and no other adequate support system; or

C. Members approved for In-Home Supportive Services.

IX. Eligibility for Day Habilitation Program

A. Members who are experiencing homelessness,

B. Members who exited homelessness and entered housing in the last twenty-four (24) months; and

C. Members at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

X. Eligibility for Respite Services

A. Members who live in the community and are compromised in their ADLs and are therefore dependent upon a qualified caregiver who provides most of their support; and

B. Members who require caregiver relief to avoid institutional placement; or

C. Members may include children who previously were covered for Respite Services under the:

1. Pediatrics Palliative Care Waiver;

2. Foster care program beneficiaries;

3. California Children's Services;

4. Genetically Handicapped Persons Program (GHPP); or

5. Members with Complex Care Needs.

XI. Eligibility for Nursing Facility Transition for Elderly and Adult Residential Facilities

A. For Nursing Facility Transition:

1. Member has resided 60+ days in a nursing facility;

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2. Member is willing to live in an assisted living setting as an alternative to a Nursing Facility; and

3. Member is able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:

1. Member is interested in remaining in the community;

2. Member is willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and

3. Member must be:

a. Currently receiving medically necessary nursing facility Level of Care (LOC) services; and

b. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

XII. Eligibility for Community Transition Services/Nursing Facility Transition to Home

A. Member must be:

1. Currently receiving medically necessary nursing facility Level of Care (LOC) services and;

2. Choosing to transition home and continue to receive medically necessary nursing facility LOC services in lieu of remaining in the nursing facility or Medical Respite setting.

B. Member has lived 60+ days in a nursing home and/or Medical Respite setting; and

C. Member is interested in moving back to the community; and

D. Member is able to reside safely in the community with appropriate and cost-effective supports and services.

XIII. Eligibility for Environmental Accessibility Adaptions

A. Member is at risk for institutionalization in a nursing facility.

XIV. Eligibility for Asthma Remediation

A. Members with poorly controlled asthma as determined by:

1. An emergency department visit or hospitalization; or

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2. Two (2) sick or urgent care visits in the past twelve (12) months; or

3. A score of 19 or lower on the Asthma Control Test, and

4. A licensed health care provider who has documentation that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

XV. Restrictions/Limitations References

Restrictions and/or limitations for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite), Short-Term Hospitalization Housing, Medically-Tailored Meals, Sobering Centers, Personal Care/Homemaker services, Day Habilitation Program, Respite Services, Nursing Facility Transition for Elderly and Adult Residential Facilities, Community Transition Services/Nursing Facility Transition to Home, Environmental Accessibility Adaptions and Asthma Remediation are set forth in Attachment A: Community Supports Components of CalOptima Policy GG.1355.

XVI. References

A. Department of Health Care Services Medi-Cal Community Supports Policy Guide (December 2021), Section III. Community Supports – Service Definitions includes comprehensive Member eligibility criteria for Housing Transition Navigation Services, Housing Deposits, Housing Tenancy and Sustaining Services, and Recuperative Care (Medical Respite) in the Eligibility (Population Subset) sections.

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VII. Glossary

Term	Definition
Coordinated Entry System	A process which coordinates the assessment and referral of individuals and families seeking housing and includes the use of a comprehensive and standardized assessment tool. In Orange County, it includes the Family Coordinated Entry System and the Individual Coordinated Entry System.
Homeless Management Information Systems (HMIS)	A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness and is compliant with HUD's data collection, management, and reporting standards.
United States Department of Housing and Urban Development (HUD)	The Federal agency responsible for national policy and programs that address national housing needs, improve and develop communities, and enforce fair housing laws.

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Policy:	GG.1356
Title:	**Enhanced Care Management Administration**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20220303 SOD Review Only

I. PURPOSE

This Policy describes CalOptima's responsibilities for the overall administration of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative.

II. POLICY

A. CalOptima shall implement ECM in three (3) phases for Populations of Focus, as prescribed by the Department of Health Care Services (DHCS) and in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

B. CalOptima shall select ECM Providers in accordance with ECM Provider qualifications as defined by DHCS. CalOptima shall develop an ECM provider network that includes:

1. ~~All contracted~~ Health Networks to serve as the ECM Provider for their assigned Members, excluding Members authorized for ECM pursuant to Section II.B.3. of this Policy. The Member's Health Network shall communicate new Member assignments to and coordinate with the County of Orange, as the ECM Provider, as soon as possible, but in any event no later than ten (10) business days after ECM authorization by the Health Network.

2. CalOptima ~~Direct~~ to serve as the ECM Provider for Members assigned to CalOptima Community Network, excluding Members authorized for ECM pursuant to Section II.B.3 of this Policy.

    a. For CalOptima Direct Members authorized for ECM pursuant to Section II.B.3. of this Policy, CalOptima shall communicate new Member assignments to and coordinate with the County of Orange, as the ECM Provider, as soon as possible, but in any event no later than ten (10) business days after ECM authorization by CalOptima.

3. The County of Orange to serve as the ECM Provider for Members who meet the eligibility criteria for participation in or obtaining services through Orange County Specialty Mental Health System and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal program in accordance with CalOptima Policy GG.1354: Enhanced Care Management - Eligibility and Outreach.

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4. In the event the entities described in Section II.B.1 or II.B.3 of this Policy are unable to serve as an ECM Provider, a community-based ECM Provider or CalOptima shall serve as the ECM Provider for the impacted Members.

C. CalOptima shall honor Member choice in assigning Members to ECM Providers.

D. CalOptima ~~shall ensure continuity of~~ or Health Network will authorize ECM services ~~by ensuring ECM is~~to be delivered by a Member's ~~previously self-selected or~~ assigned ECM Provider, assigned Health Network, or the County of Orange (for Members meeting the eligibility criteria as described in Section II.B.3. of this Policy when authorized by CalOptima or a Health Network to be rendered by the County of Orange).

E. CalOptima shall ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member and in accordance with CalOptima Policy GG.1353: Enhanced Care Management Service Delivery.

F. CalOptima shall educate Providers about ECM services, eligibility criteria, and how to request these services for Members.

1. CalOptima shall provide training prior to ECM implementation and ongoing training and technical assistance to participating ECM Provider care management staff pursuant to Section III.F. of this Policy and in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training.

G. CalOptima shall provide written materials in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services and that are easily accessible and inform Members, family members, guardians, caregivers and/or Authorized Representatives about ECM.

H. CalOptima shall use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers, to the extent practicable, and with DHCS.

I. CalOptima shall ensure that ECM provided to Members includes all Core Service Components and that each Member is assigned a Lead Care Manager (LCM) in accordance with CalOptima Policy GG.1353: Enhanced Care Management Service Delivery.

J. CalOptima shall retain responsibility for oversight of ECM service delivery to authorized ECM Members and ensure that ECM Providers provide these services in compliance with DHCS requirements and Section III.G. of this Policy.

K. CalOptima shall provide regular feedback to ECM Providers including results of monitoring and performance against quality measures and/or metrics ~~as provided~~ in ~~CalOptima~~compliance with DHCS requirements and Section III.G. of this Policy ~~GG.1638: Performance Indicators.~~.

L. An ECM Provider shall comply with applicable Federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by Federal and State nondiscrimination laws and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

M. CalOptima shall comply with all State and Federal program reporting requirements.

N. ECM Providers shall submit data, including but not limited to information described in this Policy, to CalOptima including both standard and ad-hoc reporting to meet regulatory requirements as prescribed by CalOptima.

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III. PROCEDURE

A. ECM Providers will provide ECM, building upon their experience serving these Members in the Health Homes Program (HHP) and the Whole Person Care (WPC) Pilot, and now included in Populations of Focus.

1. This includes supporting Member-primary care provider relationships to prevent disruption of services provided by their Community-Based Care Management Entity (CB-CME) through the HHP.

2. CalOptima or a Health Network shall authorize ECM services and the ECM Provider shall be responsible for engaging Members in ECM in accordance with CalOptima Policies GG.1353: Enhanced Care Management Service Delivery and GG.1354: Enhanced Care Management - Eligibility and Outreach.

3. Each ECM Provider will deliver ECM to its assigned Members, and will respect a Member's existing provider relationships, including California Children's Services (CCS)/Whole Child Model (WCM) providers, behavioral health providers, primary care providers, and specialists.

4. ECM Providers shall communicate with Members in culturally and linguistically appropriate and accessible ways, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

5. ECM Providers shall provide a weekly return file to CalOptima via secure FTP site with record of outreach efforts, enrollment, and referrals, and other reportable data, as appropriate and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

6. CalOptima shall develop and manage its network of ECM Providers to ensure adequate capacity to meet the needs of the ECM Populations of Focus.

   a. CalOptima shall report on its ECM Provider capacity prior to implementation and on a regular basis as required by DHCS.

   b. CalOptima's ECM Provider capacity shall be evaluated separately from CalOptima's general network capacity.

   c. CalOptima shall report to DHCS sixty (60) calendar days in advance or as soon as possible on any significant change in the status of the ECM Provider capacity in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

B. CalOptima shall provide, at a minimum, the following information to all ECM Providers:

1. A monthly Member ECM eligibility file for outreach in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach;

2. Non-duplicative encounter and/or claims data, as appropriate; and

3. Non-duplicative physical, behavioral, administrative, and Social Determinants of Health data for all assigned ECM Members, as available.

C. CalOptima shall have an information technology infrastructure and data analytic capabilities to support ECM, including the capabilities to:

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1. Consume and use claims and Encounter data, as well as other data types listed in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach, to identify ECM Populations of Focus;

2. Maintain records of assignment of ECM Members to ECM Providers;

3. Keep records of all Members receiving ECM and authorizations necessary for sharing personally identifiable information between CalOptima and ECM and other Providers, among ECM Providers and family member(s), and/or support person(s), whether obtained by ECM Provider or by CalOptima;

4. Securely share data with ECM Providers and other Providers in support of ECM;

5. Receive, process, and send encounters from ECM Providers and transmit to DHCS in accordance with DHCS standards;

6. Open, track, and manage referrals to Community Supports Providers;

7. Receive and process supplemental reports from ECM Providers; and

8. Send ECM supplemental reports to DHCS.

D. CalOptima shall inform CalOptima network Providers and community-based organizations about the referral process and the CalOptima ECM Referral form, through the CalOptima website, the CalOptima Provider Manual, Provider newsletters, the Health Network Forum, CalOptima community announcements, other educational materials, as well as through community events and other regularly scheduled CalOptima stakeholder forums.

E. CalOptima shall inform Members, their family member(s), guardian, caregiver, and/or a Member's authorized support person(s) about the referral process, including how to submit a request for ECM, through the CalOptima website, Member orientation presentations, and communication with CalOptima representatives (e.g., Customer Service staff, case management staff).

F. In addition to network Provider training requirements described in CalOptima's Medi-Cal Contract with DHCS, CalOptima will provide the ECM training described below to ECM Providers including through in-person sessions, webinars, and/or calls, as necessary:

1. ECM program overview, including the care plan, care coordination, and care transition requirements for ECM as well as available community resources and referrals and operational and focused trainings.

2. Training on the CalAIM Populations of Focus, Social Determinants of Health, trauma informed care, health literacy, culturally competent communication, and data sharing requirements.

G. CalOptima shall conduct oversight of the ECM Providers by performing regular monitoring activities and shall provide regular feedback and reporting of monitoring and oversight results to the ECM Providers.

1. CalOptima shall ensure ECM Providers meet all of the following requirements:

a. Operate in areas of the county where Members reside.

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b. Are delegated to provide comprehensive care management services to CalOptima Members, including those who meet criteria for ECM Populations of Focus.

c. Continue to serve their assigned Members with respect for Member choice and cultural diversity by:

   i. Recruiting staff that reflects the cultures they serve; and

   ii. Providing care management services with cultural and linguistic competency and humility.

d. Are experienced working with the ECM Populations of Focus they will serve.

e. Have experience and expertise with the services they will provide.

f. Comply with applicable state and federal laws and regulations as well as ECM program requirements.

g. Have capacity to provide culturally appropriate and timely in-person care management activities, including accompanying Members to critical appointments when necessary.

   i. ECM Providers and Lead Care Managers shall meet ECM Members where they are in terms of the physical location that is most convenient and desirable for the Member to engage in services and from a medical management and plan of care perspective.

h. Are able to communicate in culturally and linguistically appropriate and accessible ways.

i. Have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, to coordinate care of each assigned ECM Member, as appropriate.

j. Use a care management documentation system that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of ECM Member care plans.

   i. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can:

      a) Document Member goals and goal attainment status;

      b) Develop and assign multi-disciplinary care team tasks;

      c) Define and support Member care coordination and care management needs;

      d) Gather information from other sources to identify Member needs and support multi-disciplinary care team coordination and communication; and

      e) Support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital or long-term care facility, housing status).

k. Maintain processes for sharing ECM Member care plans with other Providers and organizations involved in each ECM Member's care, as appropriate.

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2. In the case where a State level enrollment pathway exists for the ECM Provider, CalOptima shall verify that the ECM Provider is enrolled as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima shall also credential the ECM Provider in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Assessment and Re-Assessment of Organizational Providers.

    a. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima shall verify the qualifications of the provider or provider organization to ensure they meet the standards and capabilities to be an ECM Provider in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring. CalOptima shall also consider the following factors as part of CalOptima's process for vetting the qualifications and experience of ECM Providers:

        i. Ability to receive referrals from CalOptima and Health Networks for ECM;

        ii. Sufficient experience to provide services similar to ECM for Populations of Focus;

        iii. Ability to submit claims or invoices for ECM using standardized protocols;

        iv. Business licensing that meets industry standards;

        v. Capability to comply with all reporting and oversight requirements;

        vi. History of fraud, waste, and/or abuse;

        vii. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

        viii. History of liability claims against the ECM Provider.

3. CalOptima shall, through its oversight activities, hold ECM Providers accountable for all ECM requirements contained in CalOptima's Medi-Cal ECM Contract Amendment with the DHCS, associated guidance, and CalOptima's Model of Care.

4. CalOptima shall hold ECM Providers responsible for the same reporting requirements as those CalOptima has with the DHCS.

5. CalOptima shall not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting.

6. CalOptima shall not utilize tools developed or promulgated by the National Committee for Quality Assurance (NCQA) to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

7. CalOptima shall provide annual auditing of each ECM Provider, in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.4002: CalOptima Internal Oversight, to ensure accountability for requirements of the ECM and ILOS contract and compliance with ECM policies.

8. CalOptima shall monitor and ensure ECM Provider compliance with supplemental reporting requirements, as specified by DHCS.

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9. CalOptima shall provide ongoing comprehensive monitoring and oversight of the ECM Core Service Components provided by the ECM Providers at the Member level to include review of:

    a. Provision of core services;

    b. Implementation of assessment;

    c. Care plan quality; and

    d. Member contact.

10. CalOptima shall collect and aggregate ECM Provider level data to identify trends in outreach, engagement, quality of care plans, and Member contact on a quarterly basis:

    a. CalOptima shall analyze data for trends;

    b. CalOptima shall share data with the ECM Providers; and

    c. CalOptima shall work with ECM Providers to address any gaps or disparities identified.

H. CalOptima shall submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1. Encounter data:

    a. CalOptima shall submit all ECM Encounters to DHCS using national standard specifications and code sets to be defined by DHCS, regardless of whether services were provided directly or by a delegate or vendor.

    b. In the event the ECM Provider is unable to submit ECM Encounters to CalOptima using the national standard specifications and code sets to be defined by DHCS, CalOptima shall be responsible for converting ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS.

2. Supplemental reports:

    a. CalOptima shall submit ECM supplemental reports, including quarterly implementation monitoring reports, on a schedule and in a format to be defined by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and ~~In Lieu of~~Community Services ~~(ILOS)~~ Model of Care Template
B. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Policy Guide
C. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
D. Department of Health Care Services (DHCS) Managed Care Plan Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract Template

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E. CalOptima Policy DD.2002: Cultural and Linguistic Services
F. CalOptima Policy EE.1103Δ: Provider Education and Training
G. CalOptima Policy GG.1353: Enhanced Care Management Service Delivery
H. CalOptima Policy GG.1354: Enhanced Case Management - Eligibility and Outreach
I. CalOptima Policy GG.1619: Delegation Oversight
~~J. CalOptima Policy GG.1638: Performance Indicators~~
~~K.~~J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
~~L.~~K. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
~~M.~~L. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
~~N.~~M. CalOptima Policy HH.1104: Complaints of Discrimination
~~O.~~N. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
~~P.~~O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment
~~Q.~~P. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-012: Enhanced Care Management Requirements

VI. REGULATORY AGENCY APPROVAL(S)

~~None to Date~~

Date	Regulatory Agency	Response
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1356	Enhanced Care Management Administration	Medi-Cal
Revised	TBD	GG.1356	Enhanced Care Management Administration	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member or 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.
~~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.~~
Community Supports	Pursuant to 42 CFR § 438.3(e)(2), Community Supports are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Authorized Community Supports offered are included in development of CalOptima's capitation rate and count toward the medical expense component of CalOptima's Medical Loss Ratio (MLR) in accordance with 42 CFR § 438.8 (e)(2) Community Supports are optional for both CalOptima and the Member and must be approved by DHCS.
Community Supports Provider	A CalOptima-contracted Provider of the DHCS-approved Community Supports. Community Supports Providers are entities with experience and expertise providing one (1) or more of the Community Supports approved by the DHCS.
Core Service Components	The Core Service Components for ECM include: 1. Outreach and engagement; 2. Comprehensive assessment and care management plan; 3. Enhanced coordination of care; 4. Health promotion; 5. Comprehensive transitional care; 6. Member and family support; and 7. Coordination of and referral to community and social support services.
Enhanced Care Management (ECM)	A whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered. ECM is a Medi-Cal benefit.
ECM Lead Care Manager (LCM)	The Lead Care Manager (LCM) is a Member's designated care manager for ECM, who works for the ECM Provider organization and in the case of CalOptima Direct (COD) serving as the ECM Provider, the LCM could be on staff with CalOptima. The LCM operates as part of the Member's multi-disciplinary care team and is responsible for coordinating all aspects of ECM and any Community Supports. To the extent a Member has other care managers or participates in other care management programs, the LCM will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non-duplication of services.
ECM Member	A Member that is authorized for, continuously participating in, and receiving Enhanced Care Management, and assigned to a Health Network or CalOptima Direct.

For 20220503 BOD Review Only

Term	Definition
ECM Provider	A Provider within the community that has a contractual relationship with CalOptima (such as a delegated Health ~~Networks and~~Network, the County of Orange~~) or~~, CalOptima ~~acting directly (COD),~~or community-based organizations) to provide ECM services to Members authorized to receive ECM. ECM Providers have experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
Encounter	Any unit of Covered Services provided to a member by a Health Network regardless of reimbursement methodology.
Health Homes Program (HHP)	All of the California Medicaid State Plan amendments and relevant waivers that DHCS seeks and CMS approves for the provision of HHP Services that provide supplemental services to eligible Members coordinating the full range of physical health, behavioral health, and community-based MLTSS needed for chronic conditions.
Health Homes Program (HHP) Community-Based – Care Management Entities	Providers within the community that have a contractual relationship with CalOptima, or CalOptima acting directly, to provide HHP services to HHP members.
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.

For 20220303 BOD Preview Only

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Population of Focus	Subject to the phase-in requirements prescribed by DHCS and Member transition requirements for HHP and WPC, Members eligible to participate in ECM under the CalAIM initiative include the following, as defined by DHCS: 1. Adult Populations of Focus include the following: a. Individuals and families experiencing Homelessness; b. Adult high utilizers; c. Adults with Serious Mental Illness (SMI) and/or substance use disorders (SUD); d. Individuals transitioning from incarceration; e. Individuals who are at risk for institutionalization and are eligible for long-term care (LTC); f. Nursing facility residents who want to transition to the community; 2. Populations of Focus for Children and Youth include the following: a. Children (up to age 21) experiencing Homelessness; b. High utilizers; c. Serious Emotional Disturbance (SED) or identified to be a clinical high risk for psychosis or experiences a first episode of psychosis; d. Enrolled in California Children's Services (CCS) Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition; e. Involved in, or with a history of involvement in, child welfare (including foster care up to age 26); and f. Transitioning from incarceration.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, or other person or institution that furnishes Covered Services.
Social Determinants of Health	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risks. Social Determinants of Health can be grouped into 5 domains: economic stability, education access and quality, health care access and quality, neighborhood and built environment, and social and community context. Social Determinants of Health have a major impact on people's health, well-being, and quality of life. Examples of SDOH include: safe housing, transportation, and neighborhoods, racism, discrimination, and violence, education, job opportunities, and income, access to nutritious foods and physical activity opportunities, polluted air and water, and language and literacy skills.

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Policy:	GG.1356
Title:	**Enhanced Care Management Administration**
Department:	Medical Management
Section:	Case Management
Interim CEO Approval:	*/s/*
Effective Date:	01/01/2022
Revised Date:	TBD
Applicable to:	☒ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☐ Administrative

For 20220303 BOD Review Only

I. PURPOSE

This Policy describes CalOptima's responsibilities for the overall administration of Enhanced Care Management (ECM) under the California Advancing and Innovating Medi-Cal for All (CalAIM) initiative.

II. POLICY

A. CalOptima shall implement ECM in three (3) phases for Populations of Focus, as prescribed by the Department of Health Care Services (DHCS) and in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach.

B. CalOptima shall select ECM Providers in accordance with ECM Provider qualifications as defined by DHCS. CalOptima shall develop an ECM provider network that includes:

1. Health Networks to serve as the ECM Provider for their assigned Members, excluding Members authorized for ECM pursuant to Section II.B.3. of this Policy. The Member's Health Network shall communicate new Member assignments to and coordinate with the County of Orange, as the ECM Provider, as soon as possible, but in any event no later than ten (10) business days after ECM authorization by the Health Network.

2. CalOptima to serve as the ECM Provider for Members assigned to CalOptima Community Network, excluding Members authorized for ECM pursuant to Section II.B.3 of this Policy.

    a. For CalOptima Direct Members authorized for ECM pursuant to Section II.B.3. of this Policy, CalOptima shall communicate new Member assignments to and coordinate with the County of Orange, as the ECM Provider, as soon as possible, but in any event no later than ten (10) business days after ECM authorization by CalOptima.

3. The County of Orange to serve as the ECM Provider for Members who meet the eligibility criteria for participation in or obtaining services through Orange County Specialty Mental Health System and/or the Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal program in accordance with CalOptima Policy GG.1354: Enhanced Care Management - Eligibility and Outreach.

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4. In the event the entities described in Section II.B.1 or II.B.3 of this Policy are unable to serve as an ECM Provider, a community-based ECM Provider or CalOptima shall serve as the ECM Provider for the impacted Members.

C. CalOptima shall honor Member choice in assigning Members to ECM Providers.

D. CalOptima or Health Network will authorize ECM services to be delivered by a Member's assigned ECM Provider, assigned Health Network, or the County of Orange (for Members meeting the eligibility criteria as described in Section II.B.3. of this Policy when authorized by CalOptima or a Health Network to be rendered by the County of Orange).

E. CalOptima shall ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for the Member and in accordance with CalOptima Policy GG.1353: Enhanced Care Management Service Delivery.

F. CalOptima shall educate Providers about ECM services, eligibility criteria, and how to request these services for Members.

1. CalOptima shall provide training prior to ECM implementation and ongoing training and technical assistance to participating ECM Provider care management staff pursuant to Section III.F. of this Policy and in accordance with CalOptima Policy EE.1103Δ: Provider Education and Training.

G. CalOptima shall provide written materials in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services and that are easily accessible and inform Members, family members, guardians, caregivers and/or Authorized Representatives about ECM.

H. CalOptima shall use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers, to the extent practicable, and with DHCS.

I. CalOptima shall ensure that ECM provided to Members includes all Core Service Components and that each Member is assigned a Lead Care Manager (LCM) in accordance with CalOptima Policy GG.1353: Enhanced Care Management Service Delivery.

J. CalOptima shall retain responsibility for oversight of ECM service delivery to authorized ECM Members and ensure that ECM Providers provide these services in compliance with DHCS requirements and Section III.G. of this Policy.

K. CalOptima shall provide regular feedback to ECM Providers including results of monitoring and performance against quality measures and/or metrics in compliance with DHCS requirements and Section III.G. of this Policy.

L. An ECM Provider shall comply with applicable Federal and State civil rights laws and shall not discriminate on the basis of any characteristic protected by Federal and State nondiscrimination laws and in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

M. CalOptima shall comply with all State and Federal program reporting requirements.

N. ECM Providers shall submit data, including but not limited to information described in this Policy, to CalOptima including both standard and ad-hoc reporting to meet regulatory requirements as prescribed by CalOptima.

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III. PROCEDURE

A. ECM Providers will provide ECM, building upon their experience serving these Members in the Health Homes Program (HHP) and the Whole Person Care (WPC) Pilot, and now included in Populations of Focus.

1. This includes supporting Member-primary care provider relationships to prevent disruption of services provided by their Community-Based Care Management Entity (CB-CME) through the HHP.

2. CalOptima or a Health Network shall authorize ECM services and the ECM Provider shall be responsible for engaging Members in ECM in accordance with CalOptima Policies GG.1353: Enhanced Care Management Service Delivery and GG.1354: Enhanced Care Management - Eligibility and Outreach.

3. Each ECM Provider will deliver ECM to its assigned Members, and will respect a Member's existing provider relationships, including California Children's Services (CCS)/Whole Child Model (WCM) providers, behavioral health providers, primary care providers, and specialists.

4. ECM Providers shall communicate with Members in culturally and linguistically appropriate and accessible ways, in accordance with CalOptima Policy DD.2002: Cultural and Linguistic Services.

5. ECM Providers shall provide a weekly return file to CalOptima via secure FTP site with record of outreach efforts, enrollment and referrals, and other reportable data, as appropriate and in accordance with CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting.

6. CalOptima shall develop and manage its network of ECM Providers to ensure adequate capacity to meet the needs of the ECM Populations of Focus.

   a. CalOptima shall report on its ECM Provider capacity prior to implementation and on a regular basis as required by DHCS.

   b. CalOptima's ECM Provider capacity shall be evaluated separately from CalOptima's general network capacity.

   c. CalOptima shall report to DHCS sixty (60) calendar days in advance or as soon as possible on any significant change in the status of the ECM Provider capacity in accordance with CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services.

B. CalOptima shall provide, at a minimum, the following information to all ECM Providers:

1. A monthly Member ECM eligibility file for outreach in accordance with CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach;

2. Non-duplicative encounter and/or claims data, as appropriate; and

3. Non-duplicative physical, behavioral, administrative, and Social Determinants of Health data for all assigned ECM Members, as available.

C. CalOptima shall have an information technology infrastructure and data analytic capabilities to support ECM, including the capabilities to:

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1. Consume and use claims and Encounter data, as well as other data types listed in CalOptima Policy GG.1354: Enhanced Care Management – Eligibility and Outreach, to identify ECM Populations of Focus;

2. Maintain records of assignment of ECM Members to ECM Providers;

3. Keep records of all Members receiving ECM and authorizations necessary for sharing personally identifiable information between CalOptima and ECM and other Providers, among ECM Providers and family member(s), and/or support person(s), whether obtained by ECM Provider or by CalOptima;

4. Securely share data with ECM Providers and other Providers in support of ECM;

5. Receive, process, and send encounters from ECM Providers and transmit to DHCS in accordance with DHCS standards;

6. Open, track, and manage referrals to Community Supports Providers;

7. Receive and process supplemental reports from ECM Providers; and

8. Send ECM supplemental reports to DHCS.

D. CalOptima shall inform CalOptima network Providers and community-based organizations about the referral process and the CalOptima ECM Referral form, through the CalOptima website, the CalOptima Provider Manual, Provider newsletters, the Health Network Forum, CalOptima community announcements, other educational materials, as well as through community events and other regularly scheduled CalOptima stakeholder forums.

E. CalOptima shall inform Members, their family member(s), guardian, caregiver, and/or a Member's authorized support person(s) about the referral process, including how to submit a request for ECM, through the CalOptima website, Member orientation presentations, and communication with CalOptima representatives (e.g., Customer Service staff, case management staff).

F. In addition to network Provider training requirements described in CalOptima's Medi-Cal Contract with DHCS, CalOptima will provide the ECM training described below to ECM Providers including through in-person sessions, webinars, and/or calls, as necessary:

1. ECM program overview, including the care plan, care coordination, and care transition requirements for ECM as well as available community resources and referrals and operational and focused trainings.

2. Training on the CalAIM Populations of Focus, Social Determinants of Health, trauma informed care, health literacy, culturally competent communication, and data sharing requirements.

G. CalOptima shall conduct oversight of the ECM Providers by performing regular monitoring activities and shall provide regular feedback and reporting of monitoring and oversight results to the ECM Providers.

1. CalOptima shall ensure ECM Providers meet all of the following requirements:

a. Operate in areas of the county where Members reside.

b. Are delegated to provide comprehensive care management services to CalOptima Members, including those who meet criteria for ECM Populations of Focus.

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c. Continue to serve their assigned Members with respect for Member choice and cultural diversity by:

   i. Recruiting staff that reflects the cultures they serve; and

   ii. Providing care management services with cultural and linguistic competency and humility.

d. Are experienced working with the ECM Populations of Focus they will serve.

e. Have experience and expertise with the services they will provide.

f. Comply with applicable state and federal laws and regulations as well as ECM program requirements.

g. Have capacity to provide culturally appropriate and timely in-person care management activities, including accompanying Members to critical appointments when necessary.

   i. ECM Providers and Lead Care Managers shall meet ECM Members where they are in terms of the physical location that is most convenient and desirable for the Member to engage in services and from a medical management and plan of care perspective.

h. Are able to communicate in culturally and linguistically appropriate and accessible ways.

i. Have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health providers, specialists, and other entities, to coordinate care of each assigned ECM Member, as appropriate.

j. Use a care management documentation system that supports the documentation and integration of physical, behavioral, social service, and administrative data and information from other entities to support the management and maintenance of ECM Member care plans.

   i. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can:

      a) Document Member goals and goal attainment status;

      b) Develop and assign multi-disciplinary care team tasks;

      c) Define and support Member care coordination and care management needs;

      d) Gather information from other sources to identify Member needs and support multi-disciplinary care team coordination and communication; and

      e) Support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital or long-term care facility, housing status).

k. Maintain processes for sharing ECM Member care plans with other Providers and organizations involved in each ECM Member's care, as appropriate.

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2. In the case where a State level enrollment pathway exists for the ECM Provider, CalOptima shall verify that the ECM Provider is enrolled as a Medi-Cal provider, pursuant to relevant DHCS All Plan Letters (APLs), including APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment. CalOptima shall also credential the ECM Provider in accordance with CalOptima Policies GG.1650Δ: Credentialing and Recredentialing of Practitioners and GG.1651Δ: Assessment and Re-Assessment of Organizational Providers.

    a. If no Medi-Cal/Medicaid enrollment pathway exists, CalOptima shall verify the qualifications of the provider or provider organization to ensure they meet the standards and capabilities to be an ECM Provider in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.2021Δ: Exclusion and Preclusion Monitoring. CalOptima shall also consider the following factors as part of CalOptima's process for vetting the qualifications and experience of ECM Providers:

        i. Ability to receive referrals from CalOptima and Health Networks for ECM;

        ii. Sufficient experience to provide services similar to ECM for Populations of Focus;

        iii. Ability to submit claims or invoices for ECM using standardized protocols;

        iv. Business licensing that meets industry standards;

        v. Capability to comply with all reporting and oversight requirements;

        vi. History of fraud, waste, and/or abuse;

        vii. Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and

        viii. History of liability claims against the ECM Provider.

3. CalOptima shall, through its oversight activities, hold ECM Providers accountable for all ECM requirements contained in CalOptima's Medi-Cal ECM Contract Amendment with the DHCS, associated guidance, and CalOptima's Model of Care.

4. CalOptima shall hold ECM Providers responsible for the same reporting requirements as those CalOptima has with the DHCS.

5. CalOptima shall not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting.

6. CalOptima shall not utilize tools developed or promulgated by the National Committee for Quality Assurance (NCQA) to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

7. CalOptima shall provide annual auditing of each ECM Provider, in accordance with CalOptima Policies GG.1619: Delegation Oversight and HH.4002: CalOptima Internal Oversight, to ensure accountability for requirements of the ECM and ILOS contract and compliance with ECM policies.

8. CalOptima shall monitor and ensure ECM Provider compliance with supplemental reporting requirements, as specified by DHCS.

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9. CalOptima shall provide ongoing comprehensive monitoring and oversight of the ECM Core Service Components provided by the ECM Providers at the Member level to include review of:

    a. Provision of core services;

    b. Implementation of assessment;

    c. Care plan quality; and

    d. Member contact.

10. CalOptima shall collect and aggregate ECM Provider level data to identify trends in outreach, engagement, quality of care plans, and Member contact on a quarterly basis:

    a. CalOptima shall analyze data for trends;

    b. CalOptima shall share data with the ECM Providers; and

    c. CalOptima shall work with ECM Providers to address any gaps or disparities identified.

H. CalOptima shall submit the following data and reports to DHCS to support DHCS' oversight of ECM:

1. Encounter data:

    a. CalOptima shall submit all ECM Encounters to DHCS using national standard specifications and code sets to be defined by DHCS, regardless of whether services were provided directly or by a delegate or vendor.

    b. In the event the ECM Provider is unable to submit ECM Encounters to CalOptima using the national standard specifications and code sets to be defined by DHCS, CalOptima shall be responsible for converting ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS.

2. Supplemental reports:

    a. CalOptima shall submit ECM supplemental reports, including quarterly implementation monitoring reports, on a schedule and in a format to be defined by DHCS.

IV. ATTACHMENT(S)

Not Applicable

V. REFERENCE(S)

A. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) and Community Services Model of Care Template
B. Department of Health Care Services (DHCS) CalAIM Enhanced Care Management (ECM) Policy Guide
C. Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) Proposal
D. Department of Health Care Services (DHCS) Managed Care Plan Enhanced Care Management (ECM) and In Lieu of Services (ILOS) Contract Template
E. CalOptima Policy DD.2002: Cultural and Linguistic Services

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F. CalOptima Policy EE.1103Δ: Provider Education and Training
G. CalOptima Policy GG.1353: Enhanced Care Management Service Delivery
H. CalOptima Policy GG.1354: Enhanced Case Management - Eligibility and Outreach
I. CalOptima Policy GG.1619: Delegation Oversight
J. CalOptima Policy GG.1650Δ: Credentialing and Recredentialing of Practitioners
K. CalOptima Policy GG.1651Δ: Assessment and Re-Assessment of Organizational Providers
L. CalOptima Policy GG.1652: DHCS Notification of Change in the Availability or Location of Covered Services
M. CalOptima Policy HH.1104: Complaints of Discrimination
N. CalOptima Policy HH.2003: Health Network and Delegated Entity Reporting
O. Department of Health Care Services (DHCS) All Plan Letter (APL) 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment
P. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-012: Enhanced Care Management Requirements

VI. REGULATORY AGENCY APPROVAL(S)

Date	Regulatory Agency	Response
12/17/2021	Department of Health Care Services (DHCS)	Approved as Submitted
TBD	Department of Health Care Services (DHCS)	

VII. BOARD ACTION(S)

Date	Meeting
12/20/2021	Special Meeting of the CalOptima Board of Directors
TBD	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	01/01/2022	GG.1356	Enhanced Care Management Administration	Medi-Cal
Revised	TBD	GG.1356	Enhanced Care Management Administration	Medi-Cal

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IX. GLOSSARY

Term	Definition
Authorized Representative	A person designated by the Member or 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.
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For 20220303 BOD Preview Only

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

California Advancing & Innovating Medi-Cal (CalAIM) Proposal

January 2021

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1. Executive Summary

The Department of Health Care Services (DHCS) has developed a framework that encompasses broad-based delivery system, program and payment reform across the Medi-Cal program, called CalAIM: California Advancing and Innovating Medi-Cal. CalAIM advances several key priorities of the Administration by leveraging Medicaid as a tool to help address many of the complex challenges facing California's most vulnerable residents, such as homelessness, behavioral health care access, children with complex medical conditions, the growing number of justice-involved populations who have significant clinical needs, and the growing aging population.

This proposal recognizes the opportunity to provide for non-clinical interventions focused on a whole-person care approach via Medi-Cal that targets social determinants of health and reduces health disparities and inequities. Furthermore, the broader system, program, and payment reforms included in CalAIM allow the state to take a population health, person-centered approach to providing services with the goal of improving outcomes for all Californians. Attaining such goals will have significant impact on an individuals' health and quality of life and, through iterative system transformation, will ultimately reduce the per-capita costs over time. DHCS intends to work with the Administration, Legislature and our other partners on these proposals and recognizes the important need to discuss these issues and their prioritization within the state budget process. These are updated proposals based on extensive stakeholder feedback. Implementation will ultimately depend on the availability of funding and the requisite federal approvals.

CalAIM implementation was originally scheduled to begin in January 2021, but was delayed due the impact of the COVID-19 public health emergency. As a result, DHCS is proposing a new CalAIM start date of January 1, 2022.

1.1 Background and Overview

Medi-Cal has significantly expanded and changed over the last ten years, most predominantly because of changes brought by the Affordable Care Act and various federal regulations, as well as state-level statutory and policy changes. During this time, DHCS has also undertaken many initiatives and embarked on innovative demonstration projects to improve the beneficiary experience. In particular, DHCS has increased the number of beneficiaries receiving the majority of their physical health care through Medi-Cal managed care plans. These plans are able to offer more complete care coordination and care management than is possible through a fee-for-service system. They can also provide a broader array of services aimed at stabilizing and supporting the lives of Medi-Cal beneficiaries.

Depending on their needs, some beneficiaries may access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, dental,

developmental, In Home Supportive Services, etc.) in order to get their needs addressed. As one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. Therefore, in order to meet the behavioral, developmental, physical, and oral health needs of all members in an integrated, patient centered, whole person fashion, DHCS is seeking to integrate our delivery systems and align funding, data reporting, quality and infrastructure to mobilize and incentivize towards common goals.

Together, these CalAIM proposals offer solutions designed to ensure the stability of the Medi-Cal program and allow the critical successes of waiver demonstrations such as Whole Person Care Pilots, the Health Homes Program, the Coordinated Care Initiative, and the public hospital system delivery transformation, that advance the coordination and delivery of quality care to continue and be expanded to all Medi-Cal enrollees.

Our vision is that people served by our programs should have longer, healthier and happier lives. There will be a whole system, person centered approach to health and social care, in which services are only one element of supporting people to have better health and wellbeing throughout their whole lives. It will be an integrated “wellness” system, which aims to support and anticipate health needs, to prevent illness, and to reduce the impact of poor health.

The whole system, person centered approach will be equitable. Services and supports will deliver the same high quality of care, and achieve more equal health outcomes across the entire continuum of care, for all. It will improve the physical, behavioral, developmental, oral and long term services and supports, throughout their lives, from birth to a dignified end of life.

When people need support, care or treatment they will be able to access a range of services which are made seamless, and delivered as close to home as possible. Services will be designed around the individual and around groups of people, based on their unique need and what matters to them, as well as quality and safety outcomes.

To do this, we must change the expectations for our managed care and behavioral health systems. Holding our delivery system partners accountable for a set of programmatic and administrative expectations is no longer enough. We must provide a wider array of services and supports for complex, high need patients whose health outcomes are in part driven by unmet social needs and systemic racism. We must make the system changes necessary to close the gap in transitions between delivery systems, create opportunities for appropriate step-down care and mitigate social determinants of health, all hindering the ability to improve health outcomes and morbidity.

1.2 Guiding Principles

In 2018, the Care Coordination Advisory Committee developed a core set of guiding principles that were refined and established as the principles for the CalAIM initiative:

- Improve the member experience.
- Deliver person-centered care that meets the behavioral, developmental, physical, long term services and supports, and oral health needs of all members.
- Work to align funding, data reporting, quality, and infrastructure to mobilize and incentivize toward common goals.
- Build a data-driven population health management strategy to achieve full system alignment.
- Identify and mitigate social determinants of health and reduce disparities and inequities.
- Drive system transformation that focuses on value and outcomes.
- Eliminate or reduce variation across counties and plans, while recognizing the importance of local innovation.
- Support community activation and engagement.
- Improve the plan and provider experience by reducing administrative burden when possible.
- Reduce the per-capita cost over time through iterative system transformation.

1.3 Key Goals

To achieve these principles, CalAIM has three primary goals:

- Identify and manage member risk and need through whole person care approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Below is an overview of the various proposals and recommendations that make up CalAIM. See **Appendix A: 2021 and Beyond: CalAIM Implementation Timeline** for more information.

1.4 Identify and Manage Member Risk and Need Through Whole Person Care Approaches and Addressing Social Determinants of Health

California continues to strengthen integration within the state's health care delivery system aimed at achieving better care and better health. In line with these objectives, DHCS is proposing reforms that would better identify and manage member risk and need for beneficiaries who may be challenged with medical and behavioral conditions, access to care, chronic illnesses and disabilities, and require multidisciplinary care to regain health and function.

To achieve these goals, DHCS proposes the following whole system, person centered approach that focuses on addressing the needs of beneficiaries across the system with the overarching goal of improving quality of life and health.

- Develop a statewide **population health management** strategy and require plans to submit local population health mangement plans.
- Implement a new statewide **enhanced care management benefit**.
- Implement **in lieu of services** (e.g. housing navigation/supporting services, recuperative care, respite, sobering center, etc.).
- Implement **incentive payments** to drive plans and providers to invest in the necessary infrastructure to build appropriate enhanced care management and in lieu of services capacity statewide.
- Pursue participation in the **Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity**.
- Require screening and enrollment for Medi-Cal **prior to release from county jail**.
- **Pilot full integration** of physical health, behavioral health, and oral health under one contracted entity in a county or region.
- Develop a long-term plan for improving health outcomes and delivery of health care for **foster care children and youth**.

Population Health Management

Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management strategy, which is a cohesive plan of action for addressing member needs across the continuum of care based on data driven risk stratification, predictive analytics, and standardized assessment processes. Each managed care plan shall provide, at a minimum, a description of how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and

- Identify and mitigate social determinants of health and reduce health disparities or inequities.

Enhanced Care Management

DHCS proposes to establish a new, statewide enhanced care management benefit. An enhanced care management benefit would provide a whole-person approach to care that addresses the clinical and non-clinical circumstances of high-need Medi-Cal beneficiaries. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to individuals. The proposed benefit builds on the current Health Homes Program and Whole Person Care Pilots, and transitions those services to this new statewide managed care benefit to provide a broader platform to build on positive outcomes from those programs.

Proposed target populations include:

- Children or youth with complex physical, behavioral, developmental, and oral health needs (e.g. California Children Services, foster care, youth with clinical high-risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with serious mental illness (SMI), children with serious emotional disturbance (SED) or substance use disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

In Lieu of Services & Incentive Payments

In order to build upon and transition the excellent work done under California's Whole Person Care Pilots, DHCS is proposing to implement in lieu of services, which are flexible wrap-around services that a Medi-Cal managed care plan will integrate into its population health strategy. These services are provided as a substitute to, or to avoid, other covered services, such as a hospital or skilled nursing facility admission or a discharge delay. In lieu of services would be integrated with care management for members at high levels of

risk and may fill gaps in state plan benefits to address medical or social determinants of health. The current list of in lieu of services includes:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for plans and optional for beneficiaries, but the combination of enhanced care management and in lieu of services allows for a number of integration opportunities, including an incentive for building incremental change to achieve integrated managed long-term services and supports (MLTSS) in the managed care program by 2027 and building the necessary clinically-linked housing continuum for our homeless population. In order to be equipped with the required MLTSS and housing infrastructure, the state must use its ability to provide Medi-Cal managed care plans with financial incentive payments to work with their providers to invest in the necessary delivery and systems infrastructure, build appropriate care management and in lieu of services capacity, and achieve improvements in quality performance and measurement reporting that can inform future policy decisions.

SMI/SED Demonstration Opportunity

With some exceptions, federal Medicaid funding cannot be used to pay for services provided to a Medicaid beneficiary while the beneficiary is residing in an Institution for Mental Disease (IMD). This is referred to as the IMD exclusion. Generally, an IMD is a hospital, nursing home or other institution with more than 16 beds that is primarily

engaged in treating persons with mental diseases. However, the federal government has developed an opportunity for states to receive federal funding for institutional services provided to populations with a Serious Mental Illness or Serious Emotional Disturbance (SMI/SED), similar to the flexibility the state has secured for the Drug Medi-Cal Organized Delivery System (DMC-ODS) pilots. DHCS proposes to assess county interest in pursuing the SMI/SED demonstration opportunity, as long as our systems are positioned to achieve the required goals and outcomes, including building out a full continuum of care to offer beneficiaries community-based care in the least restrictive setting. Counties would voluntarily "opt-in" to participate. The main elements of the proposed SMI/SED demonstration opportunity would include:

- Ensuring high quality of care in psychiatric hospitals and residential settings, including required audits;
- Improving care coordination and transitions to community-based care;
- Increasing access to a full continuum of care including crisis stabilization and other clinically enriched forms of housing in the community with robust support services; and
- Earlier identification and engagement in treatment including through increased integration.

In pursuing this demonstration opportunity, counties that "opt-in" should be prepared to build out a robust continuum so individuals who begin at a higher level of institutional care can be stepped down to a less restrictive, community-based, residential setting.

Mandatory Medi-Cal Application Process upon Release from Jail and County Juvenile Facilities

Justice-involved individuals often receive both medical and behavioral health services while incarcerated. Upon release from jail or county juvenile facilities, proper coordination is needed to ensure the medical and behavioral health needs of an individual continue to be met, and additionally ensure critical non-clinical needs, such as housing, transportation, and overall integration back into the community are met. Studies have shown that these types of care coordination activities reduce unnecessary emergency room and inpatient stays, as well as improve treatment and medication adherence upon release from jail. To ensure all county inmates receive timely access to Medi-Cal services upon release from incarceration, DHCS proposes that California mandate a county inmate Medi-Cal application process by January 2023. Additionally, DHCS is proposing to mandate that jails and county juvenile facilities implement a process for facilitated referral and linkage from county institution release to county specialty mental health, Drug Medi-Cal, DMC-ODS, and Medi-Cal managed care plans when the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

Full Integration Plans

DHCS would like to test the effectiveness of an approach to provide full integration of physical health, behavioral health, and oral health under one contracted entity. Due to the complexity of the policy considerations around this concept, DHCS will need to conduct extensive stakeholder engagement around issues such as eligibility criteria for entities, administrative requirements across delivery systems, provider network requirements, quality and reporting requirements, as well as complex financial considerations due to the current realignment and Proposition 30 structure of behavioral health. Given the complexity of this proposal and time needed for consideration and planning, DHCS expects that the first selected full integration plans would go live no sooner than 2027.

Develop a Long-Term Plan for Foster Care

In June 2020, DHCS launched the Foster Care Model of Care Workgroup to provide an opportunity for stakeholders to weigh in on a long-term plan and strategy for improving health outcomes and the delivery of fully-integrated health care services for foster care children and youth. The workgroup will complete its work in June 2021. Based on input from the workgroup, DHCS and the California Department of Social Services (CDSS) will develop a plan of action, which may involve budget recommendations, waiver amendments, state plan changes or other activities.

1.5 Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

Medi-Cal provides services to some of California's most vulnerable and medically complex beneficiaries, but many of the services vary depending on the county one lives in. DHCS is proposing to standardize and reduce complexity by implementing administrative and financial efficiencies across the state and aligning delivery systems to provide more predictability and reduce county-to-county differences. These reforms stretch across managed care, behavioral health, dental, and other county-based services.

To achieve such goals, DHCS proposes the following recommendations.

Managed Care

- Standardize managed care enrollment statewide
- Standardize managed care benefits statewide
- Transition to statewide managed long-term services and supports
- Require Medi-Cal managed care plans be National Committee for Quality Assurance (NCQA) accredited
- Implement regional rates for Medi-Cal managed care plans

Behavioral Health

- Behavioral health payment reform
- Medical necessity criteria
- Administrative behavioral health integration statewide
- Regional contracting
- Drug Medi-Cal Organized Delivery System (DMC-ODS) program renewal and policy improvements

Dental

- New benefit: Caries Risk Assessment Bundle for young children (0 to 6 years of age) and Silver Diamine Fluoride for young children (0 to 6 years of age) and specified high-risk and institutional populations, as described in detail below.
- Pay for Performance for two adult and 17 children preventive services codes and continuity of care through a Dental Home

County-Based Services

- Enhance oversight and monitoring of Medi-Cal Eligibility
- Enhance oversight and monitoring of California Children's Services and the Child Health and Disability Prevention program
- Improving beneficiary contact and demographic information

Managed Care

Managed Care Enrollment

DHCS proposes requiring all non-dual eligible Medi-Cal beneficiaries by January 2022 and all full- and partial-benefit dual beneficiaries by January 2023, statewide, to be enrolled mandatorily in a managed care plan. The one exception is for those for whom managed care enrollment is not appropriate due to limited scope of benefits or limited time enrolled. The goal is to align managed care enrollment practices that currently vary by aid code, population, and geographic location.

Standardize Managed Care Benefits

DHCS proposes to standardize managed care plan benefits, so that all Medi-Cal managed care plans provide the same benefit package by 2023. Some of the most significant changes are to carve-in institutional long-term care and major organ transplants into managed care statewide.

Transition to Statewide Managed Long-Term Services and Supports

To achieve a more standardized approach to comprehensive care coordination for all populations, DHCS is proposing to discontinue the Cal MediConnect pilot program at the end of calendar year 2022. DHCS proposes to transition from the pilot approach of the Coordinated Care Initiative (CCI) to standardized mandatory enrollment of dual eligibles into managed care. The goal is to achieve Medi-Cal benefits integration of long-term care into managed care for all Medi-Cal populations statewide, and to transition Cal MediConnect plans to Medicare Dual-Eligible Special Needs Plans (D-SNPs). This will be done in phases:

January 2022: The Coordinated Care Initiative (CCI) proceeds as today, except that the Multipurpose Senior Services Programs benefit would be carved out of managed care. DHCS will also implement voluntary in lieu of services at this time.

January 2023: Full transition to mandatory enrollment of dual eligibles into managed care. Further, all dual and non-dual fee-for-service (FFS) Medi-Cal beneficiaries residing in a long-term care facility will be enrolled in a managed care plan effective January 1, 2023. In addition, Medi-Cal managed care plans operating in CCI counties will be required to operate Medicare D-SNPs to transition the Cal MediConnect demonstration to a permanent, ongoing federal authority and to coordinate members' Medi-Cal and Medicare benefits.

January 2025: Medi-Cal managed care plans in non-CCI counties will be required to operate Medicare D-SNPs.

The purpose of these transitions and phases is to achieve a long-term goal of implementing MLTSS statewide in Medi-Cal managed care beginning in 2027, by providing enough time and incentive to develop the needed infrastructure. This will allow many duals to receive needed MLTSS and home and community-based services statewide through their managed care plan, instead of through a variety of 1915(c) HCBS waivers that currently have capped enrollment and are not statewide.

NCQA Accreditation of Medi-Cal Managed Care Plans

In order to streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their health plan subcontractors to achieve National Committee for Quality Assurance (NCQA) accreditation by 2026. DHCS plans to use NCQA findings to certify or deem that Medi-Cal managed care plans meet certain state and federal Medicaid requirements.

Regional Rates

DHCS proposes to shift the development of Medi-Cal managed care plan rates from a county-based model to a regional rate model. The proposal to move to regional rates has two main benefits. The first benefit is a decrease in the number of distinct actuarial rating cells that are required to be submitted to CMS for review and approval. The reduction in rating cells will simplify the presentation of rates to CMS and allow DHCS to pursue/implement financing advancements and innovations utilizing a more flexible rate model. The second benefit of regional rates is cost averaging across all plans. This will continue to incentivize plan cost efficiencies, as plan rates will be inclusive of the costs within the multi-county region. This shift will produce a larger base for the averaging beyond the experience of plans operating within a single county. This change is fundamental to the ability of DHCS to implement and sustain the other changes proposed in CalAIM.

Behavioral Health

Behavioral Health Payment Reform

The state, in partnership with counties, must take serious steps to continue to invest in and improve access to mental health and substance use disorder (SUD) services for Medi-Cal beneficiaries. Behavioral health transformation is a critical priority for the Governor, the California Health and Human Services Agency, and for DHCS. We recognize that we need to improve quality of and access to care for children and other vulnerable populations. In order to achieve true system transformation, DHCS is committed to first achieving behavioral health payment reform, where DHCS will transition counties from a cost-based reimbursement methodology to a structure more consistent

with incentivizing outcomes and quality over volume and cost. This shift is being designed in conjunction with our county partners and will enable counties to participate in broader delivery system transformation efforts and engage in value-based payment arrangements with their health plan partners to support better coordination and integration between physical and behavioral health. This shift will be done thoughtfully with a key focus on ensuring no disruption of services or financial challenges for our county partners.

Behavioral health payment reform is an essential step to other opportunities for the counties around behavioral health integration, regional contracting and delivery system investments needed to advance a high-quality continuum of care for mental health and SUD services in the community.

Revisions to Behavioral Health Medical Necessity

The medical necessity criteria for specialty mental health services is outdated, lacks clarity, and should be re-evaluated. This issue creates confusion, misinterpretation, and could affect beneficiary access to services as well as result in disallowances of claims for specialty mental health and substance use disorder services. DHCS is proposing to update behavioral health medical necessity criteria to more clearly delineate and standardize requirements and to improve access for beneficiaries to appropriate services statewide.

Administrative Behavioral Health Integration

Approximately half of individuals with a serious mental illness (SMI) have co-occurring substance use and those individuals would benefit from integrated treatment. The state covers Medi-Cal SUD and specialty mental health services through separate county contracts, which makes it difficult for counties and contracted providers to offer integrated treatment to individuals with co-occurring disorders. For example, counties are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. In order to comply with these separate processes, providers offering integrated treatment to a Medi-Cal beneficiary must document SUD treatment services separately from specialty mental health services. The purpose of this proposal is to streamline the administrative functions for SUD and specialty mental health services.

Behavioral Health Regional Contracting

Small counties could optimize resources through regional administration and delivery of specialty mental health and SUD services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to provide services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such

as the local Medi-Cal managed care plan or County Medical Services Program, to create administrative efficiencies across multiple counties. Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. Furthermore, DHCS encourages counties to join the Drug Medi-Cal Organized Delivery System (DMC-ODS) or provide DMC services through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program Renewal and Policy Improvements

DHCS proposes to update the DMC-ODS program, based on experience from the first several years of implementation. Accordingly, DHCS proposes clarifying and/or changing policies to support the goal of improved beneficiary access to care, quality of care, and administrative efficiency.

Dental

The Department set an initial goal to achieve at least a 60 percent dental utilization rate for eligible Medi-Cal children. To continue progress toward achieving this goal, and based on lessons learned from the Dental Transformation Initiative (DTI), DHCS proposes the following statewide reforms for Medi-Cal dental coverage:

- Add new dental benefits based on the outcomes and successes from the DTI that will provide better care and align with national oral health standards. The proposed new benefits include a Caries Risk Assessment Bundle for young children and Silver Diamine Fluoride for young children and specified high-risk and institutional populations; and
- Continue and expand Pay for Performance Initiatives initiated under the DTI that reward increasing the use of preventive services and establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult Medi-Cal enrollees.

County Partners

Enhancing County Oversight and Monitoring: Eligibility

This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS remains compliant with federal and state eligibility and enrollment requirements. These enhancements will be developed and implemented in direct collaboration with our county partners.

Enhancing County Oversight and Monitoring: CCS and CHDP

There are several programs – including California Children's Services, the Medical Therapy Program, and the Child Health and Disability Prevention program – that provide services to over 750,000 children in Medi-Cal. The state delegates certain responsibilities for these high-risk children to California's 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach). The state needs to enhance the oversight of counties to ensure they comply with applicable state and federal requirements. Enhancing monitoring and oversight will eliminate disparities in care and reduce vulnerabilities to the state and counties, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

Improving Beneficiary Contact and Demographic Information

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which beneficiary contact and demographic information can be updated by other entities and the means to accomplish this, while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services programs, Medi-Cal beneficiaries, managed care plans, and the provider community.

1.6 Advancing Key Priorities

As DHCS has assessed the changes proposed under CalAIM, it has become apparent that these proposals are critically dependent upon each other -- without one, the others are neither possible nor powerful.

These reforms are fundamental to achieve the overall goals of improving the system and outcomes for Medi-Cal beneficiaries as well as providing long-term fiscal and programmatic sustainability to the Medi-Cal program and delivery system. In developing these recommendations, DHCS has recognized that individual proposals are significantly less likely to be achievable and successful if other key proposals are not pursued. For example, absent the proposed financing changes with respect to both the regional rate setting for Medi-Cal managed care and the structural changes to Medi-Cal behavioral health financing, the ability of our partnered plan and county entities to institute the changes focused on value-based and integrated delivery of care are significantly harder and potentially impossible to achieve.

These fundamental financing changes would not be possible without the elimination of differences across counties with respect to the delivery systems through which Medi-Cal benefits are delivered. Nearly every other proposal contained within CalAIM (such as enhanced care management, in lieu of services, and incentive payments, as well as the possibility of future full integration pilots) is critically dependent on the success of others.

The Medi-Cal program has evolved over the multiple decades since inception with ever-increasing system and fiscal complexities. CalAIM offers DHCS and the entire State of California an opportunity to take a step back to better assess what Medi-Cal beneficiaries need and alter the delivery systems accordingly, while at the same time working to be more effective and efficient with the finite funding available for the program.

CalAIM aligns with and advances several key priorities of the Administration. At its core, CalAIM recognizes the impact of Medi-Cal on the lives of its beneficiaries well beyond just accessing health services in traditional delivery settings. CalAIM establishes a foundation where investments and programs within Medi-Cal can easily integrate, complement and catalyze the Administration's plan to respond to the state's homelessness crisis; support reforms of our justice systems for youth and adults who have significant health issues; build a platform for vastly more integrated systems of care; and move toward a level of standardization and streamlined administration required as we explore single payer principles through the Healthy California for All Commission.

Furthermore, CalAIM will translate a number of existing Medi-Cal efforts such as Whole Person Care and the Health Homes Program, the prescription drug Executive Order, improving screenings for children, proliferating the use of value-based payments across our system, including in behavioral health and long-term care, into the future of the program. CalAIM will also support the ongoing need to increase oversight and monitoring of all county-based services, including specialty mental health and substance use disorder services, Medi-Cal eligibility administration, and other key children's programs currently administered by our county partners.

Below is an overview of the impact CalAIM could have on certain populations, if approved and funded as proposed:

Health for All: In addition to focusing on preventive and wellness services, CalAIM will identify patients with high and emerging risk/need and improve the entire continuum of care across Medi-Cal. This will ensure the system more appropriately manages patients over time, through a comprehensive array of health and social services spanning all levels of intensity of care, from birth and early childhood to end of life.

High Utilizers (top 5%): It is well documented that the highest utilizers represent a majority of the costs in Medi-Cal and in Medicaid nationally. CalAIM proposes enhanced care management and in lieu of services (such as housing-related services, transitions, respite, and sobering centers) that address the clinical and non-clinical needs of these high-cost Medi-Cal beneficiaries. The initiative envisions a collaborative and interdisciplinary whole person care approach to providing intensive and comprehensive care management services to improve health and mitigate social determinants of health.

Behavioral Health: CalAIM's behavioral health proposals would initiate a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services. It aligns the financing of behavioral health with that of physical health, which provides financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care. Similarly, the reforms in CalAIM simplify administration of, and access to, integrated behavioral health care.

Vulnerable Children: CalAIM is designed to improve and streamline care for medically complex children to ensure they get their physical, behavioral, developmental, and oral health needs met. It aims to identify innovative solutions for providing low-barrier, comprehensive care for children and youth in foster care and furthers the efforts already underway to improve preventive services for children, including identifying the complex impacts of trauma, toxic stress, and adverse childhood experiences through, among other things, a reexamination of the existing behavioral health medical necessity definition.

Homelessness and Housing: The addition of in lieu of services would build capacity to the clinically-linked housing continuum for our homeless population, and would include housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.

Justice-Involved: Under the proposed Medi-Cal pre-release application mandate, enhanced care management and in lieu of services would provide the opportunity to better coordinate medical, behavioral health, and non-clinical social services for justice-involved individuals prior to and upon release from county jails and county juvenile

facilities. These efforts will support scaling of diversion and re-entry efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities, further aligning with other state hospital efforts to better support care for those who are incompetent to stand trial and other forensic state-responsible populations.

Aging Population: In lieu of services, carving in long-term care statewide, mandatory Medi-Cal managed care enrollment, and aligned enrollment for dual eligible beneficiaries in Medi-Cal and D-SNP plans would allow the state to build infrastructure over time to provide MLTSS statewide by 2027. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the California's Master Plan for Aging.

1.7 From Medi-Cal 2020 to CalAIM

Through CalAIM, DHCS is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Medicaid Section 1115 authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating the required budget neutrality for waivers. CMS in recent guidance has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools.

In addition, given that California has significant learnings from our past Section 1115 demonstrations, DHCS believes a primary shift to the use of other authorities is now appropriate to allow us to expand beyond limited pilots to more statewide initiatives. These factors, combined with federal managed care regulations, has encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for delivery system transformation in the Medi-Cal program.

This proposal outlines all elements of the Medi-Cal 2020 waiver and how they will, or will not, be incorporated in to CalAIM. DHCS does not believe California is losing any critical funding or ability to improve and advance the delivery systems and ultimately improve the beneficiary experience and outcomes. In fact, the proposed shift will allow programs or pilots that have traditionally lived outside the core managed care system, where nearly 85% of all Medi-Cal beneficiaries receive care, to be brought into the main fold of the managed care delivery system.

In March 2020, as COVID-19 community spread accelerated, the State of California moved quickly to stem the spread by enacting one the nation's earliest stay-at-home orders. This stay-at-home order was accompanied by suspension of non-essential medical procedures, transition to telehealth for many services, transition to telework for administrative staff, and reprioritization of health care resources and training, including infection control measures, to address COVID. While the stay-at-home order and related delivery system changes slowed the spread of the virus, these changes caused significant disruption to the overall health care delivery system, and the economy, in California.

As a result, DHCS received multiple requests from organizations representing the state's health care delivery systems (e.g. counties, provider organizations, hospitals, behavioral health directors, and managed care plans). Stakeholders uniformly requested that, since providers and other partners are not able to properly prepare for CalAIM implementation given the focus and attention needed to respond to the COVID-19 emergency, the state request an extension of the Medi-Cal 2020 Section 1115 waiver.

In recognition, the Governor's revision to the state budget released in May 2020 postponed funding for CalAIM. This confluence of events prevented the state from moving ahead with the negotiation and implementation of CalAIM with a January 1, 2021 start. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

We look forward to working in close partnership with our federal CMS colleagues and local partners to ensure that the Medi-Cal program continues to change in ways that ultimately further the goals of improved health and outcomes, as well as cost-effectiveness, of the Medi-Cal/Medicaid program.

1.8 CalAIM Stakeholder Engagement

DHCS released the original CalAIM proposal in October 2019 ahead of an intensive four-month stakeholder engagement process. Between November 2019 and February 2020, five topic-specific workgroups comprised of stakeholders across the state participated in a series of robust in-person meetings. During these discussions, Workgroup members provided real-time feedback on the proposals as they evolved and offered helpful considerations with respect to implementation and operations. The public also had the opportunity to provide feedback on the proposals, both during the workgroup sessions and in writing. This iteration of the CalAIM proposal incorporates the broad range of

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feedback received during the stakeholder engagement process. It should be noted that this resulting proposal is dependent on the funding availability through the state budget process, and federal approvals.

1.9 Conclusion

CalAIM is an ambitious but necessary proposal to positively affect Medi-Cal beneficiaries' quality of life by improving the entire continuum of care across Medi-Cal, and ensuring the system more appropriately manages patients over time through a comprehensive set of health and social services spanning all levels of intensity of care, from birth to end of life.

CalAIM:

- Keeps all beneficiaries healthy by focusing on preventive and wellness services, while also identifying and assessing member risk and need on an ongoing basis, during transitions in care, and across delivery systems, through effective care coordination.
- Creates a fundamental shift in how California organizes and administers specialty mental health and substance use disorder services, and aligns the financing of behavioral health with physical health, providing financial flexibility to innovate, and enter into value-based payment arrangements that improve quality and access to care.
- Ensures medically complex children and adults get their physical, behavioral, developmental, and oral health needs met.
- Builds capacity in a clinically-linked housing continuum via in lieu of services for California's homeless population, including housing transition navigation services, housing deposits, housing tenancy and sustaining services, short-term post hospitalization housing, recuperative care for inpatient transitions, and day habilitation programs.
- Provides the opportunity to better coordinate clinical and non-clinical services for justice-involved individuals prior to and upon release from jail and county juvenile facilities.
- Allows the state to build infrastructure over time to provide Managed Long-Term Services and Supports (MLTSS) statewide. MLTSS will provide appropriate services and infrastructure for integrated care and home and community-based services to meet the needs of aging beneficiaries and individuals at risk of institutionalization and is a critical component of the State's Master Plan for Aging.

2. Identifying and Managing Member Risk and Need through Whole Person Care Approaches and Addressing Social Determinants of Health

This section will walk through proposals to identify and manage member risk and need:

- Population Health Management Program
- Enhanced Care Management
- In Lieu of Services
- Shared Risk, Shared Savings, and Incentive Payments
- SMI/SED Demonstration Opportunity
- Full Integration Plans
- Long-Term Plan for Foster Care

2.1 Population Health Management Program

2.1.1 Background

DHCS currently does not have a specific requirement for Medi-Cal managed care plans to maintain a population health management (PHM) program, which is a model of care and a plan of action designed to address member health needs at all points along the continuum of care. Many Medi-Cal managed care plans have a population health management program – often in the context of meeting National Committee for Quality Assurance (NCQA) requirements – but some do not. In the absence of a population health management program, beneficiary engagement is often driven by a patchwork of requirements that can lead to gaps in care and a lack of coordination.

The goal of this proposal is to improve health outcomes and efficiency through standardized core population health management requirements for Medi-Cal managed care plans, including NCQA requirements and additional DHCS requirements. The population health management program will be comprehensive and address the full spectrum of care management – including assessing population level and individual member health risks and health-related social needs, creating wellness, prevention, case management, care transitions programs to address identified risks and needs, and using stratification to identify and connect adult and pediatric members to the appropriate programs. Additionally, Medi-Cal managed care plans will develop predictive analytics about which members, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports.

2.1.2 Proposal

All Medi-Cal managed care plans shall develop and maintain a whole system, person-centered population health management program, where the plan will partner with contracted health care providers and community-based partners to identify and address members' health and health-related social needs. Medi-Cal managed care plans shall consult with their local public health department and county behavioral health department during the development of the population health management program.

The population health management program shall meet NCQA standards for population health, regardless of whether the plan is NCQA accredited. In addition to the NCQA accreditation processes, the population health management program description must be filed with the state via the population health management template (forthcoming). After the initial program description submission, the Medi-Cal managed care plan will submit certain portions of the program description, including any changes, to DHCS annually, but significant portions of the program description will only be required to be submitted to DHCS once every three years.

Each Medi-Cal managed care plan shall include, at a minimum, a description of how it will meet the core objectives to:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination;
- Identify and mitigate social determinants of health; and
- Reduce health disparities or inequities.

The population health management program shall:

- Include the goal to improve the health outcomes of communities and groups;
- Utilize data to analyze community and population level health and health-related social needs and set measurable goals for improvement;
- Utilize initial and ongoing assessments of data to analyze individual member's needs and identify groups and individuals within groups for targeted interventions;
- Provide assistance for members to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, slow the progression of

disease or disability, and support members with serious illness as their disease progresses;

- Coordinate care across the continuum of medical, behavioral health, developmental, oral health, and long-term services and supports, including tracking referrals and outcomes of referrals;
- Deploy strategies to address individual needs and mitigate social determinants of health;
- Deploy strategies to drive improvements in health for specific populations proactively identified as experiencing health disparities;
- Partner with appropriate community-based providers to support individual members, families, and caregivers in managing care.
- Utilize evidence-based practices in screening and intervention;
- Utilize a person-centered and family-centered approach for care planning; and
- Continually evaluate and improve on the population health management program strategy on an ongoing basis through meaningful quality measurement.

Assessment of Risk and Need

1. Initial Data Collection and Population Risk Assessment

As reflected in the NCQA Population Health program requirements and the DHCS Population Needs Assessment All Plan Letter (APL), the Medi-Cal managed care plan shall collect electronically available data sources in order to analyze data that capture the information on member health status and utilization (including physical, behavioral, and oral health), health-related social needs, and linguistic, racial, and cultural characteristics. As part of the population health management requirements, DHCS will continue to apply the existing Population Needs Assessment (PNA) APL requirements to hold the Medi-Cal managed care plans accountable for a PNA, which include requirements for analyzing health disparities and engaging external stakeholders as part of the process. DHCS will consult with NCQA to ensure the PNA APL data requirements meet NCQA data requirements for the population assessment.

The PNA requires that Medi-Cal managed care plans collect and analyze this data across the plan's entire Medi-Cal member population to identify opportunities at a population level to improve health. One example of how this might be done is through a type of analysis commonly known as "hot spotting." As noted in the PNA and NCQA

requirements, key issues Medi-Cal managed care plans must analyze in the assessment include:

- Acute, chronic, and prevention/wellness health needs;
- Areas of clinically inappropriate, over and under-utilization of health care resources;
- Opportunities for better care management and quality improvement;
- Health disparities by race, ethnicity, language, and functional status; and
- Health-related social needs at the community or local level.

The results of the PNA will inform the development of programs and strategies that the Medi-Cal managed care plan will use to address the needs of specific populations. Determining which individuals have access to these specific programs and strategies will be driven by the subsequent member-level risk stratification, population segmentation, and case management activities. Consistent with the PNA APL, Medi-Cal managed care plans must use the assessment to develop and implement an action plan to address community and population needs. DHCS does not currently plan to provide more specific requirements regarding community and population-level program development, but in the population health management template, Medi-Cal managed care plans will be asked indicate what they will be doing in this area, which also may be a focus of future learning collaborative best practice work.

2. Initial Risk Stratification, Segmentation and Tiering

Risk stratification or segmentation will enable Medi-Cal managed care plans to identify specific members who may benefit from wellness, prevention, and disease management activities; members who can benefit from case management; and members who are at risk for developing complex health issues. Consistent with NCQA Population Health program requirements, Medi-Cal managed care plans will be required to risk stratify and segment members into groups that it will use to develop and implement case management, wellness, and health improvement programs and strategies. Medi-Cal managed care plans will also be required to use DHCS-defined criteria to tier its members into four risk tier categories and report that information to DHCS.

Consistent with the NCQA Population Health program requirements, Medi-Cal managed care plans shall conduct the risk stratification and segmentation and DHCS risk tiering using an integrated data and analytics stratification process that considers at least the following sources:

- Previous screening or assessment data;
- Disengaged member reports;
- Claims or encounter data, including all fee-for-service data provided by DHCS;

- And to the extent available:
    - Available social needs data, including housing status ICD-10 data; and
    - Electronic health records.

Risk Stratification or Segmentation: Medi-Cal managed care plans will analyze each individual's data based on the minimum, mandatory list of data sources described above and will then risk stratify and segment members into meaningful sub-populations. The Medi-Cal managed care plan will use risk stratification and segmentation to identify specific members who may benefit from targeted interventions and programs designed to meet identified member needs. Risk stratification and segmentation must occur within 44 days of the effective date of plan enrollment.

The Medi-Cal managed care plan may use its own algorithm to risk stratify or segment its population or it may use the DHCS-defined risk tiers described below as a starting point for further stratification and segmentation. The design of the algorithm, including how the data is stratified and segmented as part of the algorithm, should be informed by the health needs identified through the population assessment and designed so that the Medi-Cal managed care plan can group individual members into meaningful categories and subsequently outreach to individual members within those categories for tailored interventions and programs designed to achieve specific health outcomes. Medi-Cal managed care plans will incorporate enhanced care management into their segmentation in accordance with DHCS enhanced care management target population guidance and Medi-Cal managed care plan flexibility afforded for the enhanced care management benefit. When risk stratifying its member population, Medi-Cal managed care plans must use a validated risk grouper.

Risk stratification or segmentation algorithms shall include past medical and behavioral health service utilization but must also incorporate other data such as health conditions, risk factors, and disease progressions, in order to avoid exacerbating underlying biases in utilization data that may drive health disparities. Medi-Cal managed care plans must analyze the results of its stratification/segmentation algorithm to identify and correct any biases the algorithm may introduce based on race, ethnicity, language, functional status, or other sources of health disparities. In the population health management program description, the Medi-Cal managed care plan will submit to DHCS its list of stratification/segmentation data sources, the risk stratification/segmentation algorithm (or the name of the tool if it is proprietary), and also the method of bias analysis. To promote transparency and best practices, these three pieces of information will be made available for public viewing on DHCS' website and will also be a focus of continuing Medi-Cal managed care plan learning collaborative activities.

Based on the risk stratification/segmentation and the findings from Individual Risk Assessment (IRA) described below, the Medi-Cal managed care plan will link the member with the appropriate services including, but not limited to, wellness and prevention, general case management, complex case management, enhanced care management, in lieu of services (as available) external entity coordination, and transition coordination. Specific minimum requirements for each of these categories are listed in their own sections below.

DHCS Risk Tiering Requirements. This risk tiering process, including the IRA described below, will satisfy federal Medicaid Managed Care Final Rule requirements for initial risk assessment. Medi-Cal managed care plans will use DHCS-defined criteria to assign each member into one of four risk tiers: (1) low risk; (2) medium and rising risk; (3) high risk; and (4) unknown risk. The criteria for these tiers will be developed by DHCS.

The types of criteria used will be similar (but not the same) as the DHCS criteria for risk stratifying seniors and persons with disabilities (SPDs) into low- and high-risk groups. The criteria will align with the questions that DHCS will develop for the IRA survey tool, which is addressed in the next section. “High risk” members are those who are at increased risk of having an adverse health outcome or worsening of their health status. “Medium and rising risk” members are those that are stable at a medium risk level and those whose health status suggest they have the potential to move into the high-risk category.

Members at the medium/rising and high risk levels likely require additional provider-level assessment, care coordination, and/or possibly case management, or other specific services, which will be determined by the Medi-Cal managed care plan’s population segmentation strategy and coordination with providers. “Low risk” members are those who, in general, only require support for wellness and prevention. “Unknown risk” members are those who do not have sufficient data to stratify into a risk tier and for whom the Medi-Cal managed care plan is unable to complete a member-contact screening risk assessment. The IRA survey tool will be designed to have enough information to allow for risk tier assignment on its own if there is insufficient available historical data for the member.

DHCS will develop a process to validate Medi-Cal managed care plans’ implementation of the DHCS risk tier criteria to ensure consistent application and output statewide.

3. Individual Risk Assessment Survey Tool

DHCS will develop a standardized, 10-15 question Individual Risk Assessment (IRA) Survey Tool. There will be two versions, one for children and one for adults. Medi-Cal managed care plans will use the IRA to: (1) confirm or revise the initial DHCS risk tier to which the member was assigned; (2) gather consistent information for members without sufficient data; and (3) add information that will be used as part of its own stratification/segmentation algorithms and population health management strategy.

DHCS' goal in the development of the IRA questions will be to ensure they are validated and can be used with a scoring mechanism so that the IRA information can be integrated into the Medi-Cal managed care plan's risk stratification/segmentation process. DHCS will translate the questions into the threshold languages. Medi-Cal managed care plans will have the flexibility to add questions of their choosing to the IRA and would then also translate those additional questions into all threshold languages. It is expected that Medi-Cal managed care plans will conduct subsequent and separate screenings (or add supplemental questions) to identify specific issues and priorities to address.

The IRA will replace the assessments below:

- Staying Healthy Assessment/Individual Health Education Behavioral Assessment (SHA/IHEBA)
- Health information form/member evaluation tool (HIF/MET)
- Health risk stratification and assessment survey for SPDs
- Whole Child Model Assessment
- The Initial Health Assessment (IHA) provider visit (within 120 days of enrollment) will remain a requirement, but DHCS contracts and policies will not specify provider requirements for that visit.

Medi-Cal managed care plans will continue to be required to ensure the provision of preventive and other services in accordance with contractual requirements and accepted standards of clinical care.

Members assigned to the DHCS medium/rising, high, and unknown risk tiers must be contacted within 90 (medium/rising) and 45 (high and unknown) calendar days respectively to assess their needs. The IRA may be done via multiple modalities, including phone, in-person, electronic, or mail, as long as the screening responses can be transposed into an electronic format that allows for data mining and data exchange of key elements with DHCS. Data exchange of IRA elements with DHCS is not required at this time. Medi-Cal managed care plans should use this modality flexibility to maximize successful contact. Medi-Cal managed care plans shall make at least three (3) attempts to contact a member using available modalities.

If the Medi-Cal managed care plan is unable to obtain a completed IRA from a member, it has the option to create a process for working with the member's assigned primary care provider to: 1) have the member complete the assessment with them; and 2) transfer the resulting information to the Medi-Cal managed care plan.

Medi-Cal managed care plans will use the IRA information to assign or revise the member's DHCS risk tier. Once that process is complete, Medi-Cal managed care plans will be responsible for reporting the member's assigned risk tier to DHCS in an electronic format to enable better tracking and assessment of the impacts of the population health

management program. The Medi-Cal managed care plan will also share information regarding the assigned member's risk tier to the member's assigned PCP in an electronic format. If the member transfers to another Medi-Cal managed care plan, DHCS will provide the member's risk tier to the new Medi-Cal managed care plan.

The IRA questions will align with the DHCS-specified criteria for high, medium/rising, and low risk tiers. It is DHCS's intent that the structure of the IRA will meet NCQA requirements for a Health Appraisal.

- The IRA will include 10-15 questions, which seek to identify preliminary risk information for the following elements: Behavioral, developmental, physical, Long Term Services and Supports, and oral health needs;
- Emergency department visits within the last six months;
- Self-assessment of health status and functional limitations;
- Adherence to medications as prescribed;
- Assessment of health literacy and cultural and linguistic needs;
- Desire or need for case management;
- Ability to function independently and address his/her own health needs;
- Access to basic needs such as education, food, clothing, household goods, etc.;
- Use or need for long-term services and supports;
- Availability of social supports and caregiver;
- Access to private and public transportation;
- Social and geographic isolation; and
- Housing and housing instability assessment;

4. Reassessment

At a minimum, the Medi-Cal managed care plan shall reassess risk and need, including rising risk, of all members annually both the DCHS risk tiering and its own risk stratification/segmentation process. Individual members' risk and need may need to be re-evaluated throughout the year based on a change in condition or level of care, such as an inpatient admission or new diagnosis, the availability of new data, or a case management interaction.

Medi-Cal managed care plans must describe what events or data trigger the re-evaluation process for individual members. In the population health management program description, the Medi-Cal managed care plan must inform DHCS what minimum risk groups would require regular assessment in between the annual risk stratification process. However, this does not limit the Medi-Cal managed care plan from conducting additional assessments beyond what is defined as required by DHCS.

5. Provider Referrals

Medi-Cal managed care plans must establish a process by which providers may make referrals for members to receive case management or services for other emerging needs. Referrals for case management should lead to a re-evaluation of risk stratification and DHCS risk tier assignment. Medi-Cal managed care plans must consider and integrate information received through referrals when determining members' risk stratification.

Actions to Support Wellness and Address Risk and Need

1. General Requirements and Services

The Medi-Cal managed care plan shall integrate required activities with the population health management program as appropriate including, but not limited to member services, utilization management, referrals, transportation, health/plan/benefit education, appointment assistance, warm-handoffs to community-based organizations or other delivery systems, system navigation, primary care provider member assignment, community outreach, preventive services, and screenings for all members.

The Medi-Cal managed care plan shall provide a toll-free line for primary care providers and specialists who seek technical and referral assistance when any physical or behavioral condition requires further evaluation or treatment. Available information shall include assistance in arranging for referrals, including mental health and SUD treatment referrals, developmental services referrals, dental referrals, referrals to home-based medical/social services for people with serious illness, and referrals to long-term services and supports. Communication about the availability of this consultation service shall be found on the front-page of the Medi-Cal managed care plan's website and in materials supplied to providers.

The Medi-Cal managed care plan shall provide a 24-hours-a-day, 7-days-a-week, toll-free nurse advice line for members who seek technical, clinical, and referral assistance for physical, oral, and behavioral health services to address urgent needs.

The Medi-Cal managed care plan shall demonstrate how they support practice change activities, the deployment of evidence-based tools for providers, and models of service delivery that optimize health care and coordinated health care and social services. Finally, the Medi-Cal managed care plan shall develop or provide access to a current and updated community resource directory for case managers and contracted providers.

2. Wellness and Prevention Services

The Medi-Cal managed care plan shall provide wellness and prevention services in accordance with NCQA and contractual requirements. The population health management program shall integrate wellness and prevention services for all members, regardless of risk tier, according to the benefits outlined in the managed care contract including, but not limited to, the following:

- Provide preventive health visits, developmental screenings, and services for:
  - All children (under 21 years of age) in accordance with the American Academy of Pediatrics Bright Futures periodicity schedule.
  - All adults in accordance with US Preventive Services Task Force Grade "A" and "B" recommendations.
- Monitor the provision of wellness and preventive services by primary care providers as part of the Medi-Cal managed care plan Facility Site Review process.
- Provide health educational materials about topics such as disease management, preventive services, Early and Periodic Screening, Diagnostic, and Treatment services, how to access benefits, and other managed care plan health promotion materials.

3. Managing Members with Medium/Rising Risks

The population health management program shall:

- Provide screening for Adverse Childhood Experiences (ACEs) for children and adults, based on the recommended periodicity schedule as specified in the Medi-Cal managed care contract.
- Ensure members receive appropriate follow-up for behavioral, developmental, physical, and oral health needs including preventive care, care for chronic conditions, and referrals to long-term services and supports, as appropriate;

- Refer members identified, through assessment or re-assessment, as needing care coordination or case management to the member's case manager for follow-up care and needed services within 30 calendar days; and

- Assess individual social care needs and deploy appropriate community resources and strategies to mitigate the adverse childhood experiences (ACEs) toxic stress and impacts of social determinants of health in partnership with providers and community organizations.

Additionally, Medi-Cal managed care plans will be required to use predictive analytics to inform them about which patients, communities or populations are emerging as high risk as well as identify and address the needs of outliers with more specific services and supports. To address this focus, Medi-Cal managed care plans shall incorporate the DHCS Population Needs Assessment and NCQA Population Health program requirements on this topic into their population health management strategy. Identifying and addressing the needs of specific high-risk communities and populations – sometimes referred to as "hot spotting" – will be a focus of the population health management learning collaborative and DHCS will continue to assess best practices in this area.

4. Case Management

Case management services actively assist at-risk members in navigating health delivery systems and acquiring self-care skills to improve functioning and health outcomes, slow the progression of disease or disability or prepare for the progression of a serious illness. Case management services are intended for members who are medium- or high-risk or may have rising risks that would benefit from case management services. Members determined to be low risk should continue to receive wellness and prevention services as well as other medically necessary services.

Case management services include the following, as needed and appropriate:

- Screening beyond the IRA to identify and prioritize goals and needs for case management, including both health issues, ACEs and toxic stress, and health-related social needs
- Documentation in an electronic format of the individual care plan and assigned case manager for each member (required for all case management).
- Utilization of evidence-based practices in screening and intervention.
- Ongoing review of the member's goals and care plan as well as identifying and addressing gaps in care.
- Support from an inter-professional team with one primary point of contact for the member.

- Access to person-centered planning, including advanced care planning regarding preferences for medical treatment, and education and training for providers and families.
- Continuous information sharing and communication with the member and their providers.
- Ensuring a person-centered and family-centered approach by identification of member's circle of support or caregiver(s).
- Coordination and access to medically necessary health services and coordination with entities that provide mental health, substance use disorder services, and developmental and oral health services.
- Ensuring coordination and access to community-based services, such as home care, personal care services, and long-term services and supports.
- Developing relationships with local community organizations to implement interventions that address social determinants of health (e.g. housing support services, nutritional classes, etc.).
- Coordinating authorization of services including timely approval of and arranging for durable medical equipment, pharmacy, private duty nursing, palliative care, and medical supplies.
- Promoting recovery using community health workers, peer counselors, and other community supports.
- Requesting modifications to treatment plans to address unmet service needs that limit progress.
- Assisting members in relapse and/or crisis prevention planning that includes development and incorporation of recovery action plans, and advance directives for individuals with a history of frequent mental health readmissions or crisis system utilization.
- Assisting members in care planning related to cognitive impairment, traumatic brain injury, Alzheimer's disease, and dementia.
- Performance measurement and quality improvement using feedback from the member and caregivers.
- Delivery of services in a culturally competent manner that addresses the cultural and linguistic needs by interacting with the member and his or her family in the member's primary language (use of interpreter allowed), with appropriate consideration of literacy and cultural preference.
- If the Medi-Cal managed care plan assigns a case manager outside the plan, written agreements shall define the responsibility of each party in meeting case management requirements to ensure compliance and non-duplication of services. If situations arise where a member may be receiving care coordination from multiple entities, the Medi-Cal managed care plan shall identify a lead care coordinator.

If a member changes enrollment to another Medi-Cal managed care plan, the Medi-Cal managed care plan shall coordinate transition of the member to the new plan's case management system to ensure services do not lapse and are not duplicated in the transition. The Medi-Cal managed care plan must also ensure member confidentiality and member rights are protected.

Members may be assigned to one of three types of case management based on assessment of risk and need.

The three types of case management include:

- **Basic Case Management:** Basic case management would be appropriate for members who require planning and coordination that is not at the highest level of complexity, intensity, or duration. These services are provided by the Medi-Cal managed care plan, clinic-based staff, or community-based staff, and may be provided by non-licensed staff. These services may include assignment to a certified patient-centered medical home, participation in a Medi-Cal managed care plan disease management program or participation in another Medi-Cal managed care plan population health management program.

- **Complex Case Management:** The Medi-Cal managed care plan shall provide complex case management in accordance with NCQA requirements. NCQA defines complex case management as "a program of coordinated care and services for members who have experienced a critical event or diagnosis that requires extensive use of resources." NCQA allows organizations to define "complex." Complex case management generally involves the coordination of services for high-risk members with complex conditions.

- **Enhanced Care Management:** The proposed Enhanced Care Management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to providing intensive and comprehensive care management services to targeted individuals. Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The population health management program description shall describe how and when the services are utilized in conjunction with the risk stratification process, as members with changing risk and needs may require changing levels of case management. If the Medi-Cal managed care plan delegates or contracts with a provider for case management or transition of care services, it must do so in accordance with the NCQA's population health management delegation requirements.

5. In Lieu of Services

"In lieu of services" are flexible wrap-around services that the Medi-Cal managed care plan will integrate into their population health management programs. These services are provided as a substitute or to avoid utilization of other services such as hospital or skilled nursing facility admissions, discharge delays, or emergency department use. In lieu of services should be integrated with case management for members at medium-to-high levels of risk and may fill gaps in Medi-Cal State Plan benefits to address medical or other needs that may arise due to social determinants of health. DHCS is proposing the initial use of in lieu of services to serve as a transition of the work done through existing pilots (e.g. Whole Person Care, the Health Homes Program, the Coordinated Care Initiative, etc.), as well as inform the development of future potential statewide benefits that may be instituted.

Examples of the in lieu of services that DHCS proposes to cover include many of the services currently provided in the Whole Person Care Pilot program that are not covered as Medi-Cal State Plan benefits. Some of these include, but are not limited to, respite, recuperative care, medically tailored meals, supplemental personal care services, housing tenancy navigation and sustaining services, and sobering centers. Medi-Cal managed care plans will develop a network of providers of allowable in lieu of services with consideration for which community providers have expertise and capacity regarding specific types of services. See **Appendix J: In Lieu of Services Options** for more detail.

6. Coordination between Medi-Cal Managed Care Plans and External Entities

The Medi-Cal managed care plan shall describe in the population health management program description how they will coordinate with, and refer members to, health care and social services/programs including, behavioral health services, dental, and home and community-based services. Referrals must be culturally and linguistically appropriate for the member. The Medi-Cal managed care plan must coordinate with competent external entities to provide all necessary services and resources to the member. These entities should be listed as part of the population health management program description identifying specific services each named entity will provide plan members. The Medi-Cal managed care plan's population health management

program description shall include assurance of payment to Indian Health Care Providers.

7. Transitional Services

The Medi-Cal managed care plan shall ensure transitional services are provided to all members who are transferring from one setting, or level of care, to another. The Medi-Cal managed care plan shall work with appropriate staff at any hospital that provides services to its members, whether contracted or non-contracted in the case of emergency services, to implement a safe, comprehensive discharge plan. The plan must provide continued access to medically necessary covered services that will support the member's recovery and prevent readmission.

The Medi-Cal managed care plan shall have in place operational agreements or shall incorporate transitional language into existing network arrangements with the Medi-Cal managed care plan's contracted community physical and behavioral health hospitals, residential treatment facilities and long-term care facilities, as applicable, to ensure smooth transitions. Transition services shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. The operational agreements shall define the responsibility of each party in meeting the following requirements:

- Completion of a standardized discharge risk assessment tool. The tool shall assess risk for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism. Each Medi-Cal managed care plan's discharge screening tool must be approved by DHCS;
- Development of a written discharge plan, shared with the beneficiary and all treating providers, to mitigate the risk of readmission and other negative health outcomes;
- Obtain the member's permission to share information with clinical and non-clinical providers to facilitate care transitions;
- Develop discharge planning policies and procedures in collaboration with all hospitals;
- Process all hospital prior authorization requests for clinic services within two business days. Such services shall include authorizations for therapy, home care services, equipment, medical supplies, and pharmaceuticals;
- Educate hospital discharge planning staff on the clinical services that require pre-authorization to facilitate timely discharge from the hospital; and
- Prevent delayed discharges from a hospital due to Medi-Cal managed care plan authorization procedures or transition to a lower level of care.

8. Skilled Nursing Facility Coordination

The Medi-Cal managed care plan shall coordinate with hospital or other acute care facility discharge planners and nursing facility case managers or social workers to ensure a smooth transition to or from a skilled nursing facility or nursing facility. The Medi-Cal managed care plan shall coordinate with the facility to provide case management and transitional care services and ensure coverage of all medically necessary services not included in the negotiated daily rate. This includes, but is not limited to, prescription medications, durable medical equipment, intravenous medications, and any other medically necessary service or product.

- If the Medi-Cal managed care plan, in coordination with the nursing facility or skilled nursing facility, anticipates the member will be in the facility after a member no longer meets criteria for medically necessary skilled nursing care or rehabilitative care, the Medi-Cal managed care plan shall assist the member in exploring all available care options. This includes potential discharge to a home or community residential setting, or to remain in the skilled nursing facility for long-term services and supports.
- If the member is discharged to a home or to a community residential setting, the Medi-Cal managed care plan shall coordinate with the facility to ensure the member is in a safe location. The plan shall ensure medically necessary services are available including, but not limited to, home health services, durable medical equipment and supplies, outpatient rehabilitation services, and any other services necessary to facilitate the member's recovery. The Medi-Cal managed care plan shall also ensure follow-up care is provided consistent with the transitional service requirements listed above.

Population Health Management Oversight

The Medi-Cal managed care plan shall have internal monitoring processes in place to ensure compliance with the population health management program requirements. Quality assurance reviews of documented population health management activities shall include:

- Case identification and assessment according to established risk stratification system;
- Electronically documented treatment plans and care plans with evidence of periodic revision as appropriate to emerging member needs;
- Referral management;
- Effective coordination of care, including coordination of services that the member receives through the fee-for-service system; and

- Identification of appropriate actions for the case manager to take in support of the member, and the case manager's follow-through in performing the identified tasks.

The Medi-Cal managed care plan shall document quality assurance reviews on an annual basis or upon DHCS' request and submit them to DHCS for review. Medi-Cal managed care plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including All Plan Letters, Policy Letters, and Dual Plan Letters. These requirements must be communicated by each Medi-Cal managed care plan to all delegated entities and sub-Medi-Cal managed care plans. The Medi-Cal managed care plan must submit a population health management oversight plan in accordance with NCQA requirements for any entities to which they delegate population health management functions. Such plans would need to be reviewed and approved by the state.

Health Information Technology to Support Integrated Care and Care Coordination

The Medi-Cal managed care plan will work to implement health information technology to support population health principles, integrated care, and care coordination across the delivery system. Examples of health information technology include, but are not limited to, electronic health records, emergency department information exchange, clinical data repositories, registries, decision support and reporting tools that support clinical decision-making, and case management. An overarching goal of the population health management program is to expand interoperable health information technology and health information exchange infrastructure, so that relevant data (including clinical and non-clinical) can be captured, analyzed, and shared to support provider integration of behavioral health and medical services, case management oversight and transitional planning, value-based payment models, and care delivery redesign.

The Medi-Cal managed care plan shall develop data exchange protocols, including member information sharing protocols, before initiating services with any subcontracted entity. Protocols must support integrated behavioral health-physical health coordination including, but not limited to, sharing of claims and pharmacy data, treatment plans or care plans, and advance directives necessary to coordinate service delivery and care management for each member in accordance with applicable privacy laws.

Improved data collection, specifically of encounter data at the provider level, is a critical component of achieving the goals of this proposal, and DHCS will be working with plans and providers to achieve this goal.

Accountability and Oversight of Medi-Cal Managed Care Plans

In order to hold Medi-Cal managed care plans accountable for the activities proposed here, DHCS will increase its oversight and assessment of the plans to include changes

to its audit procedures and the imposition of corrective action plans and financial sanctions, when appropriate. DHCS recognizes that, through this and the other CalAIM proposals, the responsibility of Medi-Cal managed care plans will increase over time, and therefore DHCS' approach to oversight and accountability must also grow and change in conjunction with these proposals. DHCS is committed to providing Medi-Cal managed care plans technical assistance to support the smooth adoption of these changes.

Future Policy Development and Technical Assistance

As technical assistance for Medi-Cal managed care plans in development of their population health management programs, DHCS will provide submission templates and best practice examples of Medi-Cal managed care plan population health management programs from California and other states. DHCS will also create a DHCS-operated learning collaborative for Medi-Cal managed care plans to share information and promising practices. The learning collaborative will foster information sharing and address promising practices in all the DHCS-required population health management activities. The following topics that have been identified by stakeholders:

- Medi-Cal managed care plan coordination and partnerships with external entities that provide carved-out services, such as specialty mental health, Drug Medi-Cal, Regional Centers, schools, public health departments, and community-based organizations that provide social services;
- Engaging with consumers who have health and social needs but are unidentified, unengaged, and are underutilizing services, including methods to engage with these members, build trust, and obtain information from the member about their needs;
- Care transition coordination including sharing discharge risk assessment tools;
- Incorporating social determinants of health and health-related social care needs into case management and community-level population improvement activities;
- Collection of social determinants of health information for risk stratification and segmentation, and for state-level data collection for strategic planning purposes;
- Best practices in how to use population health management programs to support specific populations of interest, such as children and pregnant women, in ways that align with other DHCS initiatives;
- Use of population data for "hot spotting" and other population analysis promising practices;

- Use of general beneficiary medical record release consent to allow Medi-Cal managed care plans and providers to share data broadly for the purposes of care coordination;
- Learning best practices from California Accountable Communities for Health Initiative activities, including opportunities for partnership and elements that may be appropriate to integrate into the population health management strategies;
- Data exchange protocols and the development of health information technology/health information exchange policies; and
- Submission of housing status data to DHCS via ICD-10 coding, in alignment with the current DHCS Value-Based Payment incentive program for these codes.

The best method to advance promising practices in these areas may be to allow them to emerge through a learning collaborative and assessment of Medi-Cal managed care plan outcomes. DHCS may also standardize certain requirements after further research and consultation with stakeholders.

Continuing areas of DHCS policy development will include:

- DHCS Risk Tiering criteria;
- DHCS IRA to gather individual member information for risk tiering and stratification;
- Detailed review of alignment with NCQA Population Health program requirements, in coordination with NCQA and Medi-Cal managed care plans;
- Continued exploration into what guidance DHCS can provide regarding what can be allowed for different types of information sharing between providers and Medi-Cal managed care plans to facilitate care coordination;
- Voluntary guidance from DHCS regarding Medi-Cal managed care plan collection of social determinants of health data from ICD-10 encounter coding. The guidance, and Medi-Cal managed care plan collection of this data in accordance with the guidance, will become mandatory on January 1, 2024; and
- Setting prospective, prioritized goals to improve Medi-Cal managed care population health management over five years from the implementation date. To do this, DHCS will review of population health management program outcomes goals and measures, and their relation to the broader DHCS managed care quality metric strategy, which may be used to assess each Medi-Cal managed care plan's population health management program.

2.1.3 Rationale

The population health management program requirement will ensure that there is a cohesive plan to address beneficiary needs across the continuum of care, from prevention and wellness to complex case management. This proposal will work in conjunction with other CalAIM proposals to meet the overarching CalAIM goals of improving coordination and quality, while reducing unnecessary administrative burden and redundancy. The following CalAIM elements of the population health management program will magnify the positive impact on member outcomes:

- **NCQA Accreditation** will provide a foundation of quality best practices and an oversight structure for the population health management program and other Medi-Cal managed care plan activities;
- The new **enhanced care management** benefit will provide a critical new set of services as well as an effective case management tool to integrate within the population health management program;
- The adoption of a menu of **in lieu of services** – flexible wrap-around services designed to fill medical and social determinants of health gaps – will similarly integrate within the population health management program; and
- Making **shared risk/savings and incentive payments** available to Medi-Cal managed care plans and providers will maximize the effectiveness of the population health management program and new service options.

2.1.4 Proposed Timeline

The population health management program would be implemented as part of the new Medi-Cal managed care plan contracts, with an effective date of January 1, 2023. The date for the first population health management program description submission and other required submissions from Medi-Cal managed care plans to DHCS is to be determined.

2.2 Enhanced Care Management Benefit

2.2.1 Background

Depending on the needs of the beneficiary, some individuals may need to access six or more separate delivery systems (managed care, fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.). Given the similarities in target populations across Medi-Cal delivery systems, beneficiaries are likely to be eligible for multiple programs that include some level of care management, depending on the efforts that are underway in their county of residence.

Additionally, as one would expect, the need for care coordination increases with greater system fragmentation, greater clinical complexity, and/or decreased patient capacity for coordinating their own care. The Health Homes Program and many of the Whole Person Care pilots provide such services. DHCS is proposing the implementation of a single, comprehensive enhanced care management benefit within Medi-Cal managed care. Lessons learned from the Whole Person Care pilots and the Health Homes Program will be incorporated to ensure that the new enhanced care management benefit is designed to meet the clinical and non-clinical needs for the highest cost/highest need beneficiaries in Medi-Cal and is available as a statewide benefit.

2.2.2 Proposal

The proposed enhanced care management benefit will replace the current Health Homes Program and elements of the Whole Person Care pilots, building on positive outcomes from those programs over the past several years. Based on extensive stakeholder engagement, DHCS will require that beneficiaries receiving Health Homes or Whole Person Care services are seamlessly transitioned to continue receiving care coordination services by way of the new enhanced care management benefit. Medi-Cal managed care plans will be mandated to contract with all existing local providers offering Health Homes and Whole Person Care services, with a few contractual exceptions. Medi-Cal managed care plans will be required to contract with community-based providers that have experience serving the enhanced care management target populations, and who have expertise providing the core enhanced care management services. Further, to allow non-Whole Person Care or Health Homes Program counties additional time to develop an adequate local infrastructure, a phased-in approach for implementing enhanced care management will be adopted.

It is the state's intention to implement this new initiative in a complementary, rather than duplicative manner that will build upon the strengths and foundations of these existing programs. DHCS recognizes the significant investment the Whole Person Care entities made over the past five years in building the capacity for these services. The intention is to build on those investments and infrastructure to continue the positive outcomes achieved by the Whole Person Care pilots. Additionally, as a result of extensive stakeholder feedback, DHCS has determined that Medi-Cal managed care plans will be required to coordinate enhanced care management services with county Targeted Case Management programs to ensure non-duplication of services and provide a holistic approach to care for Medi-Cal's most vulnerable beneficiaries.

The proposed enhanced care management benefit is designed to provide a whole-person approach to care that addresses the clinical and non-clinical needs of high-cost and/or high-need Medi-Cal beneficiaries enrolled in Medi-Cal managed care plans. Enhanced care management is a collaborative and interdisciplinary approach to

providing intensive and comprehensive care management services to targeted individuals.

Medi-Cal managed care plans will proactively identify members who meet the target population criteria and can benefit from enhanced care management services. The enhanced care management providers will be taking on the responsibility for coordinating services across all delivery systems. They are the primary responsible entity for coordinating across multiple medical and social service domains of care. Authorized members will be assigned a lead care manager that will have responsibility for interacting directly with the member and coordinating all primary, behavioral, developmental, oral health, and long-term services and supports, any in lieu of services, and services that address social determinants of health needs, regardless of setting.

Through collaborative leadership and systematic coordination among public and private entities, the enhanced care management benefit will serve target populations, benefit from data sharing between systems, and coordinate care in real time for beneficiaries. DHCS will evaluate individual and population progress — all with the goal of providing comprehensive care and achieving better health outcomes.

The overarching goals for enhanced care management are:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Improving health outcomes;
- Addressing social determinants of health; and
- Decreasing inappropriate utilization.

The enhanced care management target populations include: (see **Appendix I: Enhanced Care Management Target Population Descriptions** for more detailed definitions):

- Children or youth with complex physical, behavioral, developmental, and/or oral health needs (e.g. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.

- Individuals at risk for institutionalization who are eligible for long-term care services.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD) with co-occurring chronic health conditions.
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

Enhanced Care Management Design and Services

The enhanced care management benefit, which will be delivered by community-based providers (”ECM Providers”) contracting with Medi-Cal managed care plans, will provide multiple opportunities to engage beneficiaries by stratifying risk and need, developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Enhanced care management services extend beyond standard care coordination and disease management activities and are concentrated on the coordination and monitoring of cost-effective, quality direct care services for the individual, as well as connections to needed community supports for indirect care needs.

The enhanced care management benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. Enhanced care management will emphasize prevention, health promotion, continuity and coordination of care to link members to services as necessary across providers and settings and with emphasis on identifying the least restrictive and most integrated setting that will meet the needs of the beneficiary.

The role of enhanced care management is, through face-to-face visits, to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the member, including participating in the care planning process, regardless of setting. Enhanced care management activities shall become integrated with other care coordination processes and functions and shall assume primary responsibility for coordination of the member’s physical health, behavioral health, oral health, developmental, and long-term care needs.

Enhanced care management will be provided at a level dictated by the complexity of the health and social needs of the member. The approach to enhanced care management will be high-touch, on-the-ground, and face-to-face, with frequent contacts for persons residing in community settings and nursing facilities. Enhanced care management care managers are expected to develop relationships with members and their families, engage

members and families in needs assessment and care planning processes, and work with the primary care provider to address the member's needs in coordinating physical and behavioral health care.

The enhanced care management care managers will operate within the member's community, serve as the members' primary point of contact and are responsible for ensuring that applicable physical, behavioral, long-term care, developmental, oral, social, and psychosocial needs are met in the safest, least restrictive way possible while considering the most cost-effective way to address those needs. Care managers meet members where they are, both literally, and from a medical management and plan of care perspective. Community health workers can also be used to improve outreach and provide care coordination services for beneficiaries.

Required programmatic elements to be implemented include, but are not limited to, care coordination, health promotion, comprehensive transitional care, member and family supports and referral to community and social services. These elements include helping beneficiaries navigate, connect to and communicate with providers and social service systems; coaching beneficiaries on how to monitor their health and identify and access helpful resources; identifying and coordinating available in lieu of services such as housing services; helping beneficiaries move safely and easily between different care settings and reducing avoidable hospital admissions and readmissions; educating beneficiaries and their family/support system about their conditions to improve treatment adherence and medication management; providing referrals to community and social services; and follow-up to help ensure that beneficiaries are connected to the services they need.

Program Administration

Enhanced care management will be administered by the Medi-Cal managed care plans, who will have direct responsibility for establishing the enhanced care management benefit and criteria for their members, subject to contractual requirements and programmatic guidance provided by DHCS. DHCS intends for Medi-Cal managed care plans to build upon the expertise and infrastructure of the existing Whole Person Care pilots and Health Homes Program to achieve these outcomes and, with some exceptions, to contract directly with existing Whole Person Care providers and Health Homes Program community-based care management entities, as well as other necessary contracting with public and private providers to deliver such services.

In addition, DHCS expects that plans will work in coordination and collaboration, and even contract when appropriate, with county behavioral health systems who often are the primary providers of services to a subset of Medi-Cal beneficiaries. This proposal requests that managed care plans determine the service design and intensity based on the parameters established by DHCS. DHCS will build enhanced funding into the

capitation rates to enable Medi-Cal managed care plans to successfully provide enhanced care management benefit. The Medi-Cal managed care plans will have strong oversight and will perform regular auditing and monitoring activities to ensure that all requirements are met. If a plan proposes to keep some level of enhanced care management in-house instead of contracting with direct providers, the plan will need to demonstrate to the state that their enhanced care management benefit is appropriately community-based and provide a rationale for not contracting with existing WPC and HHP providers (per the exceptions outlined in the enhanced care management and in lieu of services Model of Care Template and managed care plan contract language.)

For individuals with a primary SMI diagnosis, SUD, children with SED, or children involved in child welfare, county behavioral health staff should be considered to serve as the enhanced care management provider through a contractual relationship, provided they agree to coordinate all the services (physical, developmental, oral health, long-term care and social needs) needed by those target populations, not just their behavioral health needs. These staff will focus on the behavioral health needs and interventions for the Medi-Cal beneficiary, act as a resource for the Medi-Cal managed care plan in managing the needs of this population and ensuring that beneficiaries are linked to appropriate county resources; as well as other resources that have more experience and documented success in working with those living with these conditions.

Targeted Case Management

Furthermore, Medi-Cal managed care plans will be expected to work with Local Governmental Agencies to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services; this approach will also help support the Department's goal of strengthening the connections across California's delivery systems. The Targeted Case Management program is an optional Medi-Cal Program funded by federal and local funds. See **Appendix B: Targeted Case Management** for which counties currently participate in the Targeted Case Management program.

DHCS may need to review and discuss other potential county funding interactions with this benefit to ensure there is no duplication of services or funding.

Transition and Coordination Plan

Medi-Cal managed care plans currently operating a Health Homes Program or operating in a county with a Whole Person Care pilot or Targeted Case Management program, will be required to submit a transition and coordination plan to DHCS by July 1, 2021. Through the transition and coordination plan, managed care plans will demonstrate how they will translate the existing programs into the enhanced care management benefit and in lieu of services and coordinate with existing Targeted Case Management programs. The

plans must also demonstrate a good faith effort to contract for enhanced care management and in lieu of services with existing Health Homes providers and Whole Person Care entities already providing such services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS information as to why such entities were not able to come to a contractual agreement.

Medi-Cal managed care plans in counties with Targeted Case Management programs will be required to submit information in the transition and coordination plan describing how they will work with the Local Government Agency to ensure that members receiving enhanced care management services do not receive duplicative Targeted Case Management services.

A transition and coordination plan will not be required for Medi-Cal managed care plans in counties that do not have Whole Person Care pilots, Health Homes Programs, or Targeted Case Management.

Implementation

January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.

July 1, 2022:

- Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
- All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.

January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Medi-Cal managed care plans that begin implementing on January 1, 2022 will submit an enhanced care management Model of Care proposal to DHCS for review by July 1, 2021. Draft contract provisions will be shared with plans in February 2021. Medi-Cal managed care plans that will implement enhanced care management on July 1, 2022, will submit an enhanced care management Model of Care by January 1, 2022. All plans must complete readiness activities for the mandatory target populations. Medi-Cal managed

care plans can submit to DHCS additional optional target populations, in addition to the mandatory target populations.

Federal regulations require that Medi-Cal managed care plan implementation activities shall include tribal consultation/outreach for protections involving American Indians and Indian Health Clinic providers. Through the enhanced care management Model of Care, managed care plans must demonstrate that there are sufficient Indian Health Clinics participating in their provider network to ensure timely access to services available under the contract from such providers for American Indian enrollees who are eligible to receive services. Medi-Cal managed care plans will provide a description of their coordination with tribal partners within the enhanced care management transition and coordination plan.

By July 1, 2022, all Medi-Cal managed care plans will need to submit to DHCS an enhanced care management Model of Care proposal for serving individuals transitioning from incarceration for implementation on January 1, 2023 in all counties. Re-entry transitions involve working closely with corrections departments, including probation, courts and the local county jail system to ensure connections to care once individuals are released from jail. While there is some infrastructure in place for this enhanced care management target population due to Whole Person Care Pilots, these types of arrangements require significant planning and coordination between the managed care plan, counties, sheriff, probation, and other key stakeholders.

DHCS is also looking to leverage the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act provisions that may make it possible to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release.

This aspect of enhanced care management will support the scaling of diversion efforts aimed at keeping some of the most acute and vulnerable individuals with serious medical or behavioral health conditions out of jail/prison and in their communities. In this case, Medi-Cal managed care plans can contract with county and non-profit entities that work to meet the health care needs of those who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and, thus, are at risk for incarceration and could, through care coordination and service placement, have a treatment plan built to avoid incarceration and get into community-based care and services.

Furthermore, to complement this enhanced care management benefit, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023.

Mandated County Inmate Pre-Release Application Process

In 2004, the Centers for Medicare & Medicaid Services (CMS) issued a State Medicaid Director letter, entitled "Ending Chronic Homelessness," that encouraged states to ensure that applications for Medicaid are processed in a timely manner so that individuals can receive Medicaid-covered services immediately upon release from a public institution.

On May 6, 2014, DHCS provided guidance in All-County Welfare Directors Letter #14-24, on the pre-release application process for state inmates who apply for Medi-Cal coverage. Subsequently, on June 25, 2014, DHCS clarified in All County Welfare Directors Letter #14-24E, that the guidance issued in the May 2014 letter is also applicable to county inmates. However, a specific pre-release process to facilitate the applications for county inmates was not defined and implementation of such process was voluntary.

The current pre-release application process varies from county to county. From a survey of some counties, DHCS learned that relatively larger counties with pre-release programs, such as Orange County and Stanislaus County, have agreements with third-party entities (e.g., community-based organizations or vendors) to streamline the pre-release application process and to provide dedicated application intake staff that visit individuals at the county jail while still in custody. Of the smaller counties surveyed, Yolo County has an agreement with the Sheriff's Department to establish communication channels and set up physical stations at the correctional facility, as well as security clearances for designated county staff to speak with the county inmate applicant directly. **Appendix C: County Inmate Pre-Release Application Process sample contracting Models** includes the three main models currently being used for various county inmate pre-release application programs.

DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023, which would include juvenile facilities. The goal of the proposal is to ensure the majority of county inmates/juveniles that are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to Medi-Cal services upon release from incarceration.

Additionally, DHCS is proposing to mandate that all county jails and juvenile facilities implement a process for facilitated referral and linkage from county release to county specialty mental health, Drug Medi-Cal, Drug Medi-Cal Organized Delivery Systems, and Medi-Cal managed care providers when the inmate was receiving behavioral health services while incarcerated to allow for continuation of behavioral health treatment in the community. DHCS will look to counties to implement medical record release processes that would allow medical records to be shared with the county behavioral health and Medi-Cal managed care providers, prior to or upon release from jail or county juvenile facility.

The mandated county inmate pre-release application process will standardize policy, procedures, and collaboration between California's county jails, county sheriff's departments, juvenile facilities, county behavioral health and other health and human services entities. This collaboration will ensure that eligible individuals are enrolled in Medi-Cal prior to release and will establish a continuum of care and ongoing support that may ultimately help to reduce the demand for costly and inappropriate services.

2.2.3 Rationale

DHCS continues to strengthen integration within the state's health care delivery system and is working with health promotion partners to achieve better care and better health outcomes at lower cost to the Medi-Cal program. Creating a statewide enhanced care management benefit with required target populations is consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need. The benefit will comprise an intensive set of services for Medi-Cal members who require coordination at the highest levels. Targeted individuals are beneficiaries who may be challenged with medical and behavioral conditions, access to care issues, chronic illnesses, disabilities, multiple social determinants of health, and require multidisciplinary care to regain health and function.

The enhanced care management benefit will provide Medi-Cal managed care plans with opportunities to help beneficiaries achieve improved health and well-being through stratifying risk and need and developing care plans and strategic interventions. Enhanced care management services will extend beyond standard care coordination and disease management activities. They will be concentrated on the coordination and monitoring of cost-effective, high quality, direct care services, as well as connections to needed community supports for non-direct care needs.

2.2.4 Proposed Timeline

DHCS is proposing a phased statewide implementation of the enhanced care management benefit and inclusion in Medi-Cal managed care contracts. Medi-Cal managed care plans in counties with Whole Person Care Pilots and/or Health Homes Programs will implement enhanced care management on January 1, 2022 for those target populations currently receiving Health Homes and/or Whole Person Care services. On July 1, 2022, Medi-Cal managed care plans in those counties will implement additional required target populations and counties without Whole Person Care pilots and/or Health Homes Programs will begin implementing select populations on July 1, 2022. The benefit must be implemented for in all counties all target populations, including individuals transitioning from incarceration, by January 1, 2023.

DHCS is proposing an effective date of January 1, 2023 for counties to implement a county inmate/juvenile pre-release application process. To ensure the necessary data

sharing agreements and communication plans are in place, below is detailed timeline for planning and implementation of this proposal:

- **March 1, 2021:** Establish workgroup with County Welfare Director's Association and counties to develop and vet implementation plan
- **May 1, 2021:** All county guidance development
- **November 1, 2021:** County and stakeholder feedback process
- **January 1, 2022:** Publish All County Welfare Director Letter
- **January – December 2022:** County implementation planning and technical assistance
- **January 1, 2023:** Implementation of county inmate pre-release application process

2.3 In Lieu of Services

2.3.1 Background

The Whole Person Care pilots and Health Homes Program built a foundation for an integrated approach to coordinating medical care, behavioral health, and social services to improve beneficiary health outcomes. The implementation of these programs, however, has varied across California and did not provide a statewide platform to comprehensively address the needs of beneficiaries with the most complex health challenges.

According to federal Medicaid program rules, "in lieu of services" are medically appropriate and cost-effective alternatives to services that can be covered under the State Plan. They are typically delivered by a different provider or in a different setting than traditional State Plan services. An in lieu of service can only be covered if:

- The state determines that the service is a medically appropriate and cost-effective substitute or setting for the State Plan service;
- The services are optional for the managed care plan to provide;
- The services are optional for beneficiaries and they are not required to use the in lieu of service; and
- The in lieu of services are authorized and identified in the state's Medi-Cal managed care plan contracts.

Once adopted, Medi-Cal managed care plans will integrate in lieu of services into their population health management plans – often in combination with the new enhanced care

management benefit – to address gaps in State Plan benefit services. In lieu of services may be focused on addressing combined medical and social determinants of health needs to avoid higher levels of care. For example, in lieu of services might be provided as a substitute for, or to avoid, hospital or nursing facility admissions, discharge delays, and emergency department use. Based on extensive stakeholder feedback, DHCS has updated the in lieu of services menu of services. The feedback enhanced the overall design of in lieu of services, allowing beneficiaries receiving Health Homes or Whole Person Care services to continue receiving optional plan services. Furthermore, the additional feedback optimized the depth and capacity for serving eligible beneficiaries.

2.3.2 Proposal

DHCS is proposing to include the following fourteen (14) distinct services as in lieu of services under Medi-Cal managed care. Details regarding each proposed set of services are provided in **Appendix J: In Lieu of Services Options**:

- Housing Transition/Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

The provision of in lieu of services is voluntary for Medi-Cal managed care plans and beneficiaries have the option to accept the in lieu of services or receive the State Plan services instead. Each service will have defined eligible populations, code sets, potential providers, restrictions, and limitations. However, individual in lieu of services may be used

together with other complementary in lieu of services based on individual needs and may be combined with enhanced care management services for high-risk, complex-need individuals. ILOS can be offered as an appropriate EPSDT service. Other appropriate EPSDT services should be offered in conjunction with any ILOS.

Transition and Coordination Plan

Since DHCS is building on the infrastructure developed for the Health Homes Program and parts of the Whole Person Care pilots, Medi-Cal managed care plans in counties with these programs will be required to submit a Transition and Coordination Plan to the state by July 1, 2021 demonstrating how they will transition existing programs into their enhanced care management benefit and in lieu of services. The plans must also demonstrate a good faith effort to come into agreement with and contract for enhanced care management and in lieu of services with Health Homes providers and Whole Person Care entities providing such services. DHCS recognizes the significant investment in infrastructure, as well as the existing expertise in providing these types of services, by our local county and other public/private partners and expects Medi-Cal managed care plans to partner with these entities to continue providing these critical services. If the Medi-Cal managed care plan and existing provider cannot come to agreement, the Medi-Cal managed care plans will need to provide DHCS a justification as to why the plan has not contracted with such entities.

2.3.3 Rationale

Adoption of this set of in lieu of services will provide additional support to beneficiaries with complex medical and behavioral health needs who experience socio-economic conditions that impede their ability to achieve their health goals. These circumstances put them at risk of hospitalization, institutionalization, and/or in need of other higher cost services.

Currently, Medi-Cal strategies to address beneficiaries' social determinants of health vary across the state, depending on the initiatives underway in different regions. Consistent with the CalAIM objective of reducing variation and complexity across the delivery system, as well as identifying and managing member risk and need, establishing coverage of a set of in lieu of services will make a statewide offering of these critical interventions for Medi-Cal beneficiaries.

The in lieu of services framework allows for regions that do not currently have a sufficient infrastructure to provide the full array of services to build network capacity in a way that meets the unique needs of their residents. This may include partnerships to develop physical infrastructure, as well as collaborations with new provider types who have not historically worked with Medi-Cal. This will also set the stage for Medi-Cal managed care

plans to be prepared to have long-term services and supports integrated into their care program by 2027.

The stakeholder feedback was critical to ensuring that the identified services will adequately address the critical needs of beneficiaries. The final policy incorporates feedback received regarding strategies for building the necessary service infrastructure in a cost-effective manner, finalizing the eligible populations, potential restrictions and limitations, and appropriate provider types to deliver this new set of services.

2.3.4 Proposed Timeline

January 1, 2022: DHCS is proposing statewide implementation and inclusion of in lieu of services in Medi-Cal managed care plan contracts. DHCS will provide technical assistance to plans as they prepare to implement this new set of services.

2.4 Shared Risk, Shared Savings, and Incentive Payments

2.4.1 Background

The combination of carving in long-term care statewide, enhanced care management and in lieu of services provides a number of opportunities, including an incentive for building an integrated, managed long-term services and supports program by 2027 and building the necessary clinically-linked housing continuum for our homeless population.

In order for the state to be equipped with the needed MLTSS and clinically linked housing continuum infrastructure, it is important to consider potential incentives and shared savings/risk models that could be established to encourage Medi-Cal managed care plans and providers to fully engage. Incentive funding will be focused on building a pathway for Medi-Cal managed care plans to invest in the necessary delivery and systems infrastructure, build appropriate and sustainable enhanced care management and in lieu of services capacity, and achieve improvements in quality performance that can inform future policy.

2.4.2 Proposal

DHCS proposes to create a series of incentives through a multi-pronged risk strategy. Potential approaches include:

- A blended capitation rate to account for the addition of seniors and persons with disabilities and long-term care beneficiaries into managed care. The rate will be subject to a blend true-up, which will provide financial protections in case of significant differences between actual long-term care beneficiary enrollment and assumptions used during capitation rate development.

- A time-limited, tiered, and retrospective shared savings/risk financial calculation performed by DHCS. This tiered model would be available for three calendar years – 2023, 2024 and 2025.

- A prospective model of shared savings/risk incorporated via capitation rate development. DHCS proposes to implement this approach beginning in calendar year 2026, once historical cost and utilization experience is available that would reflect the implementation of in lieu of services, long-term care services, and enhanced care management benefits statewide in managed care.

DHCS will establish plan incentives linked to delivery system reform through an investment in enhanced care management and in lieu of services infrastructure. The incentive payments will also be based on quality and performance improvements and reporting in areas such as LTSS and other cross-delivery system metrics. The target of incentive payments is to drive change at the managed care plan and provider levels. DHCS anticipates managed care plans will partner and share the incentive dollars with on-the-ground providers, including our critical partners that operate Federally Qualified Health Centers, Rural Health Centers, Indian Health Service clinics, public hospital safety net systems, and county behavioral health systems and providers to work collaboratively to meet the defined targets of incentive program.

2.4.3 Rationale

In recognition of the financial uncertainties that accompany the implementation of enhanced care management, in lieu of services, and MLTSS statewide, DHCS is committed to implementing strategies that will limit excessive financial risk (losses) for Medi-Cal managed care plans, as well as for the state and federal governments. At the same time, DHCS supports the use of strategies that will result in financial gains that can be shared between Medi-Cal managed care plans and the state and federal governments. DHCS' goal is to establish financial mechanisms that will ensure a mutual commitment to the success of the proposed short- and long-term reforms and innovations within the Medi-Cal managed care program.

DHCS' proposed risk approaches are intended to strengthen financial incentives for Medi-Cal managed care plans to:

- Divert or transition beneficiaries from long-term institutional care to appropriate home and community-based alternatives, supported by the availability of in lieu of services and enhanced care management;

- Make the necessary infrastructure investments to support the goal of transitioning to an integrated long-term services and supports program; and

- Improve quality, performance measurement, and data reporting as a pathway toward realizing better health outcomes for Medi-Cal beneficiaries.

2.4.4 Proposed Timeline

Rate setting, including associated risk strategies, is a dynamic process. Therefore, DHCS will engage and collaborate with Medi-Cal managed care plans and make future refinements as determined appropriate.

- **January – December 2021:** Develop shared savings/risk and plan incentive methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Begin implementation of managed care plan incentives.
- **No sooner than January 1, 2023:** Begin implementation of a seniors and persons with disabilities/long-term care blended rate.

2.5 Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity

2.5.1 Background

On November 13, 2018, CMS issued a State Medicaid Director letter that outlines opportunities for states to design innovative service delivery systems to improve care for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) who are enrolled in Medicaid.

This SMI/SED demonstration opportunity allows states to receive federal matching funds for services provided to Medicaid beneficiaries during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as an institution for mental disease (IMD) (e.g., psychiatric hospitals or psychiatric health facilities that have more than 16 beds), as long as it is part of a broader effort to build a robust continuum of care allowing care in the least restrictive, community-based settings. Due to the long-standing federal exclusion of Medicaid matching funds for services provided in these settings, California's counties have historically paid the full cost of inpatient mental health services provided to Medi-Cal beneficiaries in these settings.

2.5.2 Proposal

DHCS proposes that California pursue this SMI/SED demonstration opportunity to receive federal financial participation for services provided to Medi-Cal beneficiaries in an IMD. DHCS heard from stakeholders both positive and negative feedback regarding this proposal. Stakeholders in favor of the demonstration opportunity stated the additional federal funds could provide opportunities to improve service delivery and outcomes

across the continuum of care from inpatient to community-based settings, and the availability of additional matching funds would free up other local resources that counties could reinvest in strengthening other mental health services and further build the continuum of care in the community.

Proponents suggested that the demonstration opportunity is a critical component of solutions for the state hospital crisis (with long wait lists for people found incompetent to stand trial, as the state hospitals are full) and for achieving health equity, since increasing the number of short-term, crisis stabilization resources can divert people with mental illness to treatment instead of entering the justice system. People of color are disproportionately placed in justice settings instead of in mental health treatment, and lack of bed availability is a contributing factor. Stakeholders also expressed opposition based on concerns that the presence of the existing IMD exclusion is the primary safeguard in inhibiting county mental health departments from expanding the use of institutional settings and an important incentive to develop alternatives to those settings, and that using federal dollars to fund IMDs could divert resources from community-based services, undermining progress toward increased community integration and a community-based continuum of care.

On balance, DHCS believes the benefits outweigh the risks, and proposes that California submit an application to CMS using the usual process for submitting a Section 1115 waiver demonstration application. Similar to the state's existing 1115 demonstration to provide residential and other SUD treatment services under Medi-Cal, county participation would be voluntary.

2.5.3 Rationale

If California is approved to participate in the SMI/SED demonstration opportunity, federal financial participation would become available for mental health services provided to Medi-Cal beneficiaries in an IMD if all requirements are met. This additional funding would provide opportunities to improve service delivery and outcomes across a well-developed and robust continuum of care from inpatient to community-based settings, which is a requirement of this waiver. Availability of additional federal matching funds would free up other local resources, such as realignment funds, that counties may then reinvest in strengthening other mental health services and further build the continuum of care in the community.

The SMI/SED demonstration opportunity comes with many federal milestones and requirements. As of October 2020, Washington DC, Vermont, Indiana, and Idaho have approved applications, and Massachusetts, Oklahoma and Utah have pending 1115 waiver application to CMS. Below is a summary of key requirements, some of which may pose feasibility challenges:

- **Average Length of Stay:** The state would be required to achieve a statewide average length of stay of no more than 30 days for beneficiaries residing in IMDs. CMS developed guidance regarding calculations of average length of stay, clarifying that a short-term stay for acute care is limited to no more than 60 consecutive days, as long as the state continues to meet the statewide average length of stay of 30 days or less, and that states may not claim for *any* part of a stay (days 0 to 60) that exceeds 60 days.

- **Improving Community-based Services**: States participating in the SMI/SED demonstration opportunity will be expected to commit to taking several actions to improve community-based mental health care. These actions are linked to a set of goals for the SMI/SED demonstration opportunity and will milestones for ensuring quality of care in IMDs, to improve connections to community-based care following stays in acute care settings, to ensure a continuum of care is available to address more chronic, on-going mental health care needs of beneficiaries, to provide a full array of crisis stabilization services, and to engage beneficiaries with SMI/SED in treatment as soon as possible.

- **Maintenance of Effort:** According to the guidance, CMS will be examining the commitment to ongoing maintenance-of-effort on funding outpatient community-based mental health services and states must provide an assessment of current availability of mental health services. The purpose of the maintenance-of-effort requirement is to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services.

- **Data Collection & Required Measures:** The state would need to report on a common set of measures and agree to additional measures and concepts specific to the state's demonstration parameters.

- **Health Information Technology:** The state would be required to develop and submit a health information technology plan that describes the ability to leverage technology, advance health information exchange(s), and ensure interoperability in support of the demonstration's goals. The health information technology plan would address electronic care plan sharing, care coordination, and behavioral and physical health integration.

- **Staffing and Resource Considerations:** Since DHCS does not currently pay for IMD services for this target population, pursuing the demonstration and ensuring compliance with requirements would require additional staffing and resources. Similarly, counties would likely need additional resources to implement and comply with elements required by the demonstration.

For additional information about the demonstration goals and milestones, federal application requirements, and other relevant requirements, please refer to the **Appendix E: CalAIM Benefit Changes Chart** of this proposal.

2.5.4 Proposed Timeline

The SMI/SED demonstration proposal would be developed no sooner than July 1, 2022. If the waiver proposal is approved by CMS, DHCS would work with interested counties to develop a formal implementation plan, with expected launch of the demonstration in 2023-24.

2.6 Full Integration Plans

2.6.1 Background

Currently, Medi-Cal beneficiaries must navigate multiple complex managed care and fee-for-service delivery systems to meet all of their health care needs. Beneficiaries enrolled in Medi-Cal managed care plans receive physical health care and treatment for mild-to-moderate mental health conditions from their Medi-Cal managed care plan, care for SMI/SED and SUD from the county delivery system, and dental care from a separate fee-for-service delivery system or a dental managed care plan. This fragmentation can lead to gaps in care and disruptions in treatment, cost inefficiencies, and generally fails to be patient-centered and convenient for most beneficiaries. The longevity gap among individuals with serious and persistent mental illness, and the fact that this group suffers and dies from un-or under-treated chronic physical health conditions, demonstrates the need to pilot the concept of a fully integration delivery system.

2.6.2 Proposal

DHCS would like to test the effectiveness of full integration of physical health, behavioral health, and oral health under one contracted entity. Multiple Medi-Cal delivery systems (Medi-Cal managed care, county mental health plans, county Drug Medi-Cal and DMC-ODS programs) would be consolidated under one contract with DHCS. To further develop this concept, DHCS will be engaging in stakeholder conversations to inform the development of the various components associated with fully integrating health care services. Topics will include contractor selection criteria, strategies for consolidating contract requirements, subcontracting and network requirements, and delivery system administration issues such as care coordination, utilization management, quality monitoring, and external quality review organization functions.

2.6.3 Rationale

In alignment with CalAIM, fully integrating all or most of the Medi-Cal health care delivery systems under one contract would improve the beneficiary experience as well as health outcomes by eliminating fragmentation, duplication, and the need to navigate multiple systems. In addition, integration will improve access to health data/data sharing among providers and between the plan and DHCS. Full integration would also result in overall administrative simplification by consolidating and streamlining system infrastructure. An integrated delivery system would allow for more efficient coordination of care and create opportunities to identify and manage the risks and needs of the beneficiaries in a more holistic way.

As part of the CalAIM workgroup process, DHCS sought stakeholder feedback to understand the benefits, risks and considerations for plans and counties interested in participating in a full integration model. Discussion included realignment (county behavioral health participation would need to be voluntary), how non-Medi-Cal funding streams would be managed (such as MHSA), criteria for participation, the need for adequate planning and preparation, the importance of clearly defined outcome measures, and other considerations.

2.6.4 Proposed Timeline

DHCS acknowledges the complexity of this proposal, and for this reason, is proposing a go-live of no sooner than January 2027, to allow sufficient time for planning and preparation, in partnership with counties, plans and other stakeholders.

2.7 Long-Term Plan for Foster Care

2.7.1 Background

Children and youth in foster care often present with complex medical, behavioral, oral and developmental health problems rooted in their history of childhood trauma and adverse childhood experiences (ACEs) Navigating multiple systems of care can create inherent challenges. Under the Medi-Cal program, beneficiaries receive services through various delivery systems, including Medi-Cal managed care, fee-for-service, California Children's Services, regional centers, dental county mental health plans, Drug Medi-Cal, and DMC-ODS programs. While children and youth in foster care typically have a comprehensive team to help facilitate and oversee their care including social workers, public health nurses, and the judicial system; many challenges remain in navigating Medi-Cal delivery systems, especially if there are multiple placements that may result in the child moving from one county to another or between homes in a single county.

In recent years, California has placed a greater emphasis on the behavioral health care needs of child welfare-involved children and families through major reforms such as the

Continuum of Care Reform, Family Urgent Response System, development of short-term residential treatment providers and coordinated efforts to implement the new federal Family First Prevention Services Act in California.

2.7.2 Proposal

In assessing the challenges foster care children and youth face, in June 2020 DHCS launched a workgroup of interested stakeholders to consider whether DHCS should develop a different model of care for children and youth in foster care, including the former foster youth and youth transitioning out of foster programs and services. To facilitate this discussion and develop meaningful recommendations, DHCS invited participation from key partners including but not limited to: the Department of Social Services, the Department of Education, child welfare county representatives and state-level associations, Medi-Cal managed care plans, behavioral health managed care plans, juvenile justice and probation, foster care consumer advocates, regional centers, and judicial entities involved with matters pertaining to children who are placed into the foster care system. DHCS also commissioned focus groups with foster youth and foster parents, to hear directly from those most affected by the challenges in the current system.

2.7.3 Proposed Timeline

DHCS launched the workgroup in June 2020, and will meet every other month through June 2021. DHCS and CDSS then will take lessons learned from the workgroup and the input from stakeholders and develop a comprehensive set of recommendations and plan of action, which may involve budget recommendations, waiver amendments, State Plan changes or other activities.

3. Moving Medi-Cal to a More Consistent and Seamless System by Reducing Complexity and Increasing Flexibility

This section will walk through the proposals aimed at standardizing and reducing complexity across all delivery systems.

Managed Care

- Managed Care Benefit Standardization
- Mandatory Managed Care Enrollment
- Transition to Statewide Long-Term Services and Supports, Long-Term Care & Duals-Special Needs Plans
- NCQA Accreditation of Medi-Cal Managed Care Plans
- Regional Managed Care Capitation Rates

Behavioral Health

- Behavioral Health Payment Reform
- Medical Necessity Criteria and Other Related Changes
- Administrative Integration of Specialty Mental Health and Substance Use Disorder Services
- Behavioral Health Regional Contracting
- DMC-ODS Renewal and Policy Improvements

Dental

- New Dental Benefits and Pay for Performance

County Partners

- Enhancing County Eligibility Oversight and Monitoring
- Enhancing County Monitoring and Oversight: California Children's Services and Child Health and Disability Prevention
- Improving Beneficiary Contact and Demographic Information

Managed Care

3.1 Managed Care Benefit Standardization

3.1.1 Background

Medi-Cal delivers services through a variety of delivery systems today including fee-for-service, managed care, county mental health, Drug Medi-Cal Organized Delivery System, and Drug Medi-Cal. Most full-scope Medi-Cal beneficiaries receive their physical health

services through a Medi-Cal managed care plan. While Medi-Cal managed care exists statewide, it is operated under six different model types that currently differ based on whether certain benefits are part of the Medi-Cal managed care plan's responsibility or provided through a different delivery system.

3.1.2 Proposal

Under CalAIM, DHCS is proposing to standardize the benefits that are provided through Medi-Cal managed care plans statewide. Regardless of the beneficiary's county of residence or the plan they are enrolled in, they will have the same set of benefits delivered through their Medi-Cal managed care plan as they would in another county or plan.

DHCS is proposing the following changes:

Carved Out Benefits

- Effective April 1, 2021, all pharmacy benefits or services by a pharmacy billed on a pharmacy claim will be carved out from Medi-Cal managed care plans (pursuant to the Governor's Executive Order N-01-19 from January 7, 2019). This applies to all Medi-Cal managed care plans, including AIDS Healthcare Foundation, but does not apply to SCAN Health Plan, Programs of All-Inclusive Care for the Elderly (PACE) organizations, Cal MediConnect health plans, and Major Risk Medical Insurance Program (MRMIP).

- Effective January 1, 2022, the following benefits that are currently within the scope of some or all the Medi-Cal managed care plans will be carved out:

    - Specialty mental health services that are currently carved in for Medi-Cal members enrolled in Kaiser in Solano and Sacramento counties; and

    - The Multipurpose Senior Services Program which is currently included in the Medi-Cal managed care plans in the seven Coordinated Care Initiative counties.

Carved In Benefits

- Effective January 1, 2022, all major organ transplants, currently not within the scope of many Medi-Cal managed care plans, will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

- Effective January 1, 2023, institutional long-term care services (i.e. skilled nursing facilities, pediatric/adult subacute care, intermediate care facilities for individuals with developmental disabilities, disabled/habilitative/nursing services, specialized rehabilitation in a skilled nursing facility or intermediate care facilities), currently

not within the scope of many Medi-Cal managed care plans will be carved into all plans statewide for all Medi-Cal members enrolled in a plan.

In order to provide a smooth transition from fee-for-service to managed care, promote access and maintain affordability, DHCS proposes to require that long-term care and transplant providers accept as payment in full and require the Medi-Cal managed care plan to pay the applicable Medi-Cal fee-for-service rate, unless the provider and plan mutually agree upon an alternative payment. This is consistent with how these transitions to managed care have occurred in the past, such as with the Coordinated Care Initiative and the Whole Child Model.

3.1.3 Rationale

The standardization of benefits delivered through Medi-Cal managed care plans statewide has two main purposes and benefits:

- Beneficiaries will no longer have to deal with the confusion that may arise when moving counties/plans and to find that different benefits are covered by their new plan or that they need to access another delivery system; and
- DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.1.4 Proposed Timeline

The benefit standardization will be effective and included in Medi-Cal managed care plan contracts by January 2023, according to **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage**.

3.2 Mandatory Managed Care Enrollment

3.2.1 Background

Currently, the Medi-Cal program provides benefits through both a fee-for-service and managed care delivery system. Enrollment into the fee-for-service delivery system or the managed care delivery system is based upon specific geographic areas, the health plan model, and/or the aid code that the beneficiary is determined to qualify for. In some cases, enrolling in managed care is optional for beneficiaries. However, more than 80 percent of Medi-Cal beneficiaries are currently served through the managed care delivery system.

3.2.2 Proposal

In an effort to enhance coordination of care, increase standardization, and reduce complexity across the Medi-Cal program, DHCS is proposing to standardize which aid code groups will require mandatory managed care enrollment versus mandatory fee-for-service enrollment, across all models of care and aid code groups, statewide. Under this proposal, beneficiaries in a voluntary or excluded from managed care enrollment aid code that are currently accessing the fee-for-service delivery system, would be required to choose a Medi-Cal managed care plan and will not be permitted to remain in fee-for-service. DHCS completed extensive data analytics to inform this proposal, for example, 73% of beneficiaries with other health coverage are already enrolled in managed care today and of non-long-term care share of cost beneficiaries, on average only 5.4% of beneficiaries meet their monthly share of cost.

DHCS is proposing implementation of this change in two phases, transitioning non-dual eligible populations in 2022 and dual eligible populations in 2023. A non-dual member is defined as a Medi-Cal member without any Medicare coverage. A dual beneficiary is defined as a Medi-Cal member with any Medicare coverage. This would include Medi-Cal members with Medicare A only or Part B only (partial duals) and members with Medicare Part A and B (full duals) regardless of enrollment in Medicare Part C or Part D. See below for a summary of changes and **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage** for more details.

Given the ability and directive of Medi-Cal managed care plans to provide case and care management not available in a fee-for-service environment, DHCS firmly believes that Medi-Cal managed care is a delivery system we should continue to invest in and rely upon. In conjunction with these new and increased responsibilities, DHCS plans to increase oversight of the plans and their delegated entities to ensure that current requirements being met but also that the additional benefits and requirements contained in CalAIM are truly being provided statewide.

Mandatory Managed Care Enrollment

Below are the populations that currently receive benefits through the fee-for-service delivery system that would transition to Medi-Cal managed care upon implementation of this proposal in 2022:

- Trafficking and Crime Victims Assistance Program (except share of cost)
- Individuals participating in accelerated enrollment
- Child Health and Disability Prevention infant deeming
- Pregnancy-related Medi-Cal (Pregnant Women only, 138-213% citizen/lawfully present)
- American Indians
- Beneficiaries with other health care coverage

- Beneficiaries living in rural zip codes

Below are the populations that currently receive benefits through the fee-for-service delivery system except in COHS and CCI counties that would transition to the Medi-Cal managed care system upon implementation of this proposal in 2023:

- All dual and non-dual individuals eligible for long-term care services (includes long-term care share of cost populations)
- All partial and full dual aid code groups, except share of cost or restricted scope, will be mandatory Medi-Cal managed care, in all models of care starting in 2023

Mandatory Fee-for-Service Enrollment

This proposal would also move the following populations from mandatory managed care enrollment into mandatory fee-for-service enrollment upon implementation of this proposal in 2022:

- Omnibus Budget Reconciliation Act (OBRA): This population was previously mandatory managed care in Napa, Solano, and Yolo counties.
- Share of Cost: beneficiaries in county organized health systems (COHS) and Coordinated Care Initiative counties excluding long-term care share of cost.

Therefore, beneficiaries in the following aid code groups will have mandatory fee-for-service enrollment:

- Restricted scope
- Share of cost (including Trafficking and Crime Victims Assistance Program share of cost, excluding long-term care share of cost)
- Presumptive eligibility
- State medical parole, county compassionate release, and incarcerated individuals
- Non-citizen pregnancy-related aid codes enrolled in Medi-Cal (not including Medi-Cal Access Infant Program enrollees)

DHCS recommends keeping enrollment requirements for foster care children and youth in place until the Foster Care Workgroup makes recommendations on the future delivery system for foster care children and youth.

3.2.3 Rationale

Moving to mandatory managed care enrollment will standardize and reduce the complexity of the varying models of care delivery in California. Populations moving between counties will have the same experience when it comes to receiving services through a managed care plan. Transitioning current populations to mandatory managed care enrollment will also allow for Medi-Cal managed care plans to provide more

coordinated and integrated care and provide beneficiaries with a network of primary care providers and specialists.

Additionally, DHCS will be able to implement a change to Medi-Cal managed care plan rate setting. Currently, the capitation payment rates are developed on a county-by-county and plan-by-plan basis, resulting in excessive administrative work and challenges. With the standardization of the benefits and populations, DHCS will be able to move to a regional rate setting process that will reduce the number of rates being developed and allow DHCS to work with the managed care plans to explore different rate setting methodologies and adjustments to reward improved quality and outcomes.

3.2.4 Proposed Timeline

- **January 1, 2022:** Non-Dual and pregnancy related aid code group, and population-based transitions, except for LTC aid codes.
- **January 1, 2023:** Dual aid code group transition, including LTC aid codes for both non-dual and dual beneficiaries.

3.3 Transition to Statewide Long-Term Services and Supports, Long-Term Care, & Dual Eligible Special Needs Plans

3.3.1 Background

Under CalAIM, DHCS is proposing to transition CMC and the CCI to a statewide MLTSS and dual eligible special needs plan (D-SNP) structure. This policy is intended to help meet the statewide goals of improved care integration and person-centered care, under both CalAIM and the California Master Plan for Aging.

The Coordinated Care Initiative has been underway in seven California counties and is comprised of two parts: 1) Cal MediConnect, a demonstration project that combined acute, primary, institutional, and home and community-based services into a single benefit package for individuals who are fully or partially eligible for Medicare and Medicaid; 2) mandatory Medi-Cal managed care enrollment for dual eligibles for all Medi-Cal benefits, including managed long-term services and supports.

The Governor's 2017-2018 budget determined that the Coordinated Care Initiative was not cost-effective due to the financing of the In-Home Supportive Services benefit, which was carved out to fee-for-service effective January 1, 2018. DHCS will carve out Multipurpose Senior Services Program services to fee-for-service effective January 1, 2022 for all Medi-Cal members. CMS approved an extension for the remaining program elements – Cal MediConnect and mandatory managed long-term services and supports enrollment – until December 31, 2022.

While the Coordinated Care Initiative and Cal MediConnect offer the promise of better integrated care for California's dual eligibles, the program is only available in seven out of 58 counties. Additionally, Cal MediConnect has been a complex program to administer.

DHCS is implementing a new approach to take the key lessons learned and innovative strategies from these programs and make them more broadly available across the State.

3.3.2 Proposal

Aligned Enrollment

DHCS will use selective contracting to move toward aligned enrollment in D-SNPs; beneficiaries will enroll in a Medi-Cal managed care plan and D-SNP operated by the same parent company to allow for greater integration and coordination of care.

- In CCI counties, aligned enrollment will begin in 2023. Cal MediConnect members will transition to aligned D-SNPs and managed care plans operated by the same organization as their Cal MediConnect product.
- Aligned enrollment will phase-in in non-CCI counties as plans are ready. DHCS will require managed care plans to apply for aligned D-SNPs to be effective no later than contract year 2025.
- Dual eligible beneficiaries already enrolled in a non-aligned D-SNP (a D-SNP that is not affiliated with their managed care plan) when aligned enrollment takes effect in their county will be in that D-SNP (allowing the beneficiary to stay in the non-aligned D-SNP). New enrollment in those non-aligned D-SNPs will be closed.

In conjunction with the aligned enrollment approach, starting in 2022 CMS will limit enrollment into Medicare Advantage (MA) plans that are D-SNP “look-alikes.” These are MA plans that offer the same cost sharing as D-SNPs, but do not offer integration and coordination with Medi-Cal or other benefits targeted to the dual eligible population, such as risk assessments or care plans.

As outlined in the CMS Contract Year 2021 Medicare Advantage and Part D Final Rule:

- CMS will not enter into contracts with new MA plans that project 80 percent or more of the plan's enrollment will be entitled to Medicaid starting in 2022; and
- CMS will not renew contracts with MA plans (except SNPs) that have enrollment of 80 percent or more enrollees who are entitled to Medicaid (unless the MA plan has been active for less than one year and has enrollment of 200 or fewer individuals).

DHCS will also allow plans in CCI counties with managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans to transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP in 2022, prior to the end of CCI. This will provide better coordination of care, without reducing enrollment in Cal MediConnect plans, and is in alignment and preparation for the CMC transition to D-SNP aligned enrollment in 2023.

D-SNP Integration Requirements

DHCS will require that all D-SNPs use a model of care addressing both Medicare and Medi-Cal services to support coordinated care, high-quality care transitions, and information sharing. DHCS will work with CMS to incorporate new CalAIM model of care requirements into the D-SNP model of care, as appropriate.

As DHCS implements aligned enrollment, DHCS will require D-SNPs to:

- Develop and use integrated member materials.
- Include consumers in their existing advisory boards.
- Work with CMS to establish quarterly joint contract management team meetings for aligned D-SNP and managed care plans.
- Include dementia specialists in their care coordination efforts.
- Coordinate carved-out LTSS benefits including IHSS, MSSP, and other HCBS waiver programs.

Additionally, DHCS will work with CMS to coordinate audit timing, to avoid a D-SNP/managed care plan being audited by both agencies at the same time.

Long-Term Care Carve In

In conjunction with mandatory Medi-Cal managed care enrollment, DHCS will require statewide integration of LTC into managed care for Medi-Cal populations by 2023. This means that full- and partial-benefit duals in LTC facilities in counties or plans that do not already include LTC will be enrolled in Medi-Cal managed care by 2023.

D-SNP Transitions and Enrollment Policies

DHCS will encourage aligned enrollment of dual eligibles into matching managed care plans and D-SNPs to promote more integrated care. During all transitions, DHCS will work with CMS to ensure beneficiaries receive continuity of care protections.

Mandatory Enrollment into Medi-Cal Managed Care Plans

DHCS is committed to providing beneficiary and provider education, as well as technical assistance around Medi-Cal managed care plan requirements, for mandatory enrollment of dual eligibles into Medi-Cal managed care. As part of this work, DHCS will:

- Review and make any needed updates to education and enrollment materials used to assist dual eligibles in enrolling into a managed care plan or PACE for their Medi-Cal benefits.

- Help educate providers about necessary billing practices as well as the processes that will not change, building on materials and best practices previously developed under CCI.

3.3.3 Rationale

Individuals dually eligible for Medicare and Medi-Cal are among the highest need populations. However, lack of coordination between Medicare and Medi-Cal can make it difficult for individuals enrolled in both programs to navigate these separate systems of care. California has made significant progress in building integrated systems through the implementation of CCI and CMC in seven counties (Los Angeles, Orange, San Diego, San Mateo, Riverside, San Bernardino and Santa Clara). As part of the CalAIM initiative, DHCS is leveraging the lessons and success of CCI to develop policies to promote integrated care through D-SNPs and MLTSS across California. This includes mandatory enrollment for dual eligibles into managed care plans for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. This will allow duals to voluntarily enroll for their Medicare benefits into the D-SNP that is aligned with their managed care plan.

In addition, to promote integrated, person-centered care, the D-SNP and MLTSS policies will rely on California's robust and diverse array of HCBS providers across the state who serve older Californians and people with disabilities. In support of this effort, DHCS plans to submit a request for supplemental funding through the federal Money Follows the Person grant to accelerate LTSS system transformation design and implementation, and to expand HCBS capacity. The one-time supplemental funding would be used to develop a multi-year roadmap for implementing strategies and solutions for strengthening HCBS and MLTSS programs and provider networks. DHCS' intent is that the roadmap will provide a unified vision to integrate CalAIM MLTSS, D-SNP policy and the related in lieu of services policy, other components of the Master Plan on Aging, and all of HCBS, to expand and better link those HCBS to Medi-Cal managed care and D-SNP plans.

3.3.4 Proposed Timeline

- **January 1, 2021:** All existing D-SNPs must meet new regulatory integration standards effective 2021.

- **January 1, 2022**: Voluntary in lieu of services in all Medi-Cal managed care plans and CMC plans. Multipurpose Senior Services Program (MSSP) carved out of managed care in CCI counties. Plans in CCI counties with existing managed care plan contracts, existing D-SNPs, and existing MA D-SNP look-alike plans may transition their dual eligible populations enrolled in the MA look-alike into an existing D-SNP.

- **December 31, 2022**: Discontinue CMC and CCI.

- **January 1, 2023**: Statewide mandatory enrollment of full- and partial- benefit dual eligible beneficiaries into managed care plans for Medi-Cal benefits, including dual and non-dual eligible LTC residents and statewide integration of LTC into Medi-Cal managed care. Aligned enrollment begins in CCI counties and managed care plans in those counties must stand up D-SNPs. All CMC members cross-walked to matching D-SNP and managed care plans, subject to CMS and state requirements.

- **January 1, 2025**: Aligned enrollment begins in non-CCI counties; All managed care plans required to begin operating D-SNPs (voluntary enrollment for dual eligibles' Medicare benefit).

- **January 1, 2027**: Implement MLTSS statewide in Medi-Cal managed care.

3.4 NCQA Accreditation of Medi-Cal Managed Care Plans

3.4.1 Background

The National Committee for Quality Assurance (NCQA) is a private, not-for-profit organization that offers accreditation to health plans and other health care-related entities (e.g., accountable care organizations) in the areas of quality improvement, population health management, network management, utilization management, credentialing and re-credentialing, and member experience. NCQA also develops quality performance measures known as the Healthcare Effectiveness Data and Information Set (HEDIS) measures, which provide a standardized method for comparing health plan performance. Currently, 26 states require NCQA accreditation for their contracted Medicaid managed care plans.

DHCS conducts annual medical audits of all Medi-Cal managed care plans, but does not currently "deem," or use information obtained from a national accreditation review, to satisfy mandatory external quality review activities, with the exception of the credentialing requirement of the annual medical audit. Federal regulations permit the state to deem this information for credentialing purposes.

DHCS does not currently require Medi-Cal managed care plans to be accredited by NCQA. Out of 24 full scope Medi-Cal managed care plans in the state, 17 health plans currently have NCQA accreditation. Medi-Cal managed care plans that provide private coverage through Covered California are required to be accredited by either NCQA, the Utilization Review Accreditation Commission (URAC), or the Accreditation Association for Ambulatory Health Care (AAAHC).

3.4.2 Proposal

To streamline Medi-Cal managed care plan oversight and to increase standardization across plans, DHCS recommends requiring all Medi-Cal managed care plans and their

health plan subcontractors to be NCQA accredited by 2026. DHCS may use NCQA findings to certify or deem that Medi-Cal managed care plans meet particular state and federal Medicaid requirements. However, numerous stakeholders have shared with DHCS their concerns around DHCS deeming any elements of its current oversight of the managed care plans. Before DHCS recommends deeming of elements of its annual medical audits of the plans, DHCS will solicit feedback on the proposed deemable elements. If deeming does occur, DHCS will post information on the deeming elements and the corrective action plan for NCQA oversight findings on its website. DHCS will not accept accreditation from entities other than NCQA (e.g. URAC). Additional information on proposed deeming is below.

DHCS will also require Medi-Cal managed care plan NCQA accreditation to include the LTSS Distinction Survey subsequent to all health plans operating a D-SNP by 2027; the exact effective date for the LTSS Distinction Survey will be determined at a later date. Requiring the LTSS Survey will align with the state's effort to carve-in long-term care services and expand in lieu of services to make MLTSS a statewide benefit.

While DHCS is interested in the potential future addition of the Medicaid (MED) module to routine NCQA health plan accreditation, as it could potentially maximize the opportunity for streamlining state compliance and deeming, DHCS has determined that it is premature to require the MED module at this point, given how new it is for NCQA.

Finally, DHCS had considered requiring Medi-Cal managed care plans to ensure any non-health plan subcontractors to whom certain contractual elements are delegated are NCQA accredited for that function. DHCS will not require this in its contracts with the Medi-Cal managed care plans at this time; Medi-Cal managed care plans will need to determine if they will require any accreditation of their non-health plan subcontractors. If DHCS decides to deem particular elements of NCQA health plan accreditation standards, and any Medi-Cal managed care plans elect to require NCQA accreditation of their subcontractors, the Medi-Cal managed care plans will have the option to offer deeming on those same elements, if applicable, with their subcontractors.

3.4.3 Rationale

One of the three objectives of CalAIM is to reduce variation and complexity across Medi-Cal delivery systems, including standardization of the Medi-Cal managed care benefit. requiring NCQA accreditation of its managed care plans and following the NCQA framework, DHCS can potentially increase standardization throughout the state and reduce redundancies in various processes and assessments, in areas such as care coordination, which DHCS currently requires. Further, NCQA accreditation can assist in streamlining DHCS monitoring and oversight of managed care plans, particularly with regard to the annual medical audits, by increasing the number of elements in which DHCS may consider deeming Medi-Cal managed care plans. This would allow the annual medical audits to focus on other DHCS priority areas not reviewed by NCQA.

The addition of the LTSS Distinction Survey aligns with DHCS' goal of making LTSS a statewide benefit. DHCS recognizes that the addition of this survey to routine NCQA accreditation may be difficult for Medi-Cal managed care plans that are not already NCQA accredited, so DHCS will determine a timeframe for requiring the LTSS Distinction Survey that falls after all managed care plans have achieved routine NCQA plan accreditation.

3.4.4 Proposed Timeline

DHCS will require all Medi-Cal managed care plans and their health plan subcontractors to be NCQA accredited by 2026.

- DHCS will review and consider elements of NCQA health plan accreditation standards for deeming in relation to the annual A&I compliance audits.
    - DHCS will ensure that a complete crosswalk of federal and state Medicaid requirements and NCQA health plan accreditation standards is available online for comment prior to finalizing any deeming decisions.
    - DHCS will ensure that any NCQA health plan accreditation elements selected for potential deeming are vetted with stakeholders prior to finalizing any deeming decisions.
- DHCS may consider implementing deeming of the select elements sooner than 2026 for Medi-Cal managed care plans that already have NCQA accreditation. DHCS will align all applicable processes in its Medi-Cal managed care plan contract and All Plan Letters with the following six NCQA health plan accreditation categories to correspond with the requirement for accreditation by 2026:
    - Quality Improvement;
    - Population Health Management;
    - Network Management;
    - Utilization Management;
    - Credentialing; and
    - Member Experience.

3.5 Regional Managed Care Capitation Rates

3.5.1 Background

DHCS currently develops, certifies, and implements managed care capitation rates on an annual basis for contracted Medi-Cal managed care plans. DHCS develops distinct rates for each contracted managed care plan by county/region and population group. Due to the complexities of the Medi-Cal managed care program, which includes varied and intricate financing mechanisms, DHCS calculates multiple rating components for each capitation rate for a total of more than 4,000 rating components on an annual basis as of

state fiscal year 2018-19. The excessively large number of rating components DHCS must develop on an annual basis is administratively burdensome and contributes to lengthy annual federal review and approval timeframes. It also limits DHCS' ability to advance value-based and outcomes-focused rate setting methodologies. With the changes contemplated in CalAIM, DHCS views the need for simplified methodologies with a reduced number of components as necessary to achieving our broader goals of improving care delivery, access, quality and outcomes for our Medi-Cal beneficiaries.

3.5.2 Proposal

A regional rate-setting methodology provides a pathway toward simplification of the rate-setting process for the Medi-Cal managed care program. The proposed simplification will afford DHCS the flexibility to continue to pursue strategies that support advancements and innovations within the program.

To ensure a successful transition, DHCS proposes a two-phased approach:

Implement Regional Rates in Targeted Counties (Phase I)

- DHCS would implement Phase I for calendar years 2022 and 2023 (at a minimum) for targeted counties and Medi-Cal managed care plans;
- DHCS would advance new regional rate-setting approaches and streamline rate processes and methodologies;
- DHCS would utilize Phase I as a means of identifying strategies and further improvements that will support a seamless transition to regional rate setting statewide; and
- DHCS would engage and collaborate with contracted Medi-Cal managed care plans and industry associations as part of this process.

Fully Implement Regional Rates Statewide

- DHCS proposes to fully implement regional rates statewide no sooner than calendar year 2024, to align with the end of Phase I; and
- DHCS will consider health care market dynamics, including but not limited to health care cost and utilization data, across counties when determining regional boundaries.

3.5.3 Rationale

The proposed transition to regional rates statewide offers four main benefits:

- Regional rates would reduce the number of distinct rating components that DHCS must develop on an annual basis, and thereby permit DHCS to utilize a more flexible rate structure model. This flexibility is essential to DHCS' ability to pursue

advancements and innovations in the Medi-Cal managed care program, including CalAIM, and to explore new, innovative ideas.

- Regional rates would simplify the presentation of rates to CMS, which may expedite federal review and approval of the Medi-Cal managed care capitation rates. DHCS could implement rate-setting approaches that promote efficiency, including cost-averaging processes, across Medi-Cal managed care plans.
- These approaches would continue to incentivize Medi-Cal managed care plans to operate efficiently as rates will be based upon costs across the multi-county region. In effect, each Medi-Cal managed care plan will be incentivized to compete to be more efficient than other plans in their region.
- Regional rates would provide a larger, multi-county base for averaging, and thereby alleviate some of the criticisms regarding the process currently used by DHCS.

3.5.4 Proposed Timeline

Rate setting is a dynamic process. Therefore, DHCS will proceed methodically, engage and collaborate with Medi-Cal managed care plans, and make future refinements as determined actuarially appropriate.

- **Calendar Year 2020 and 2021:** Develop regional rate-setting methodologies and approaches with appropriate stakeholder input.
- **January 1, 2022:** Implement Phase I for targeted counties and Medi-Cal managed care plans.
- **Calendar Year 2023:** Evaluate and continue to refine the rate-setting process prior to the implementation of regional rates statewide.
- **No sooner than January 1, 2024:** Fully implement regional rates statewide.
- **Post-implementation:** Continue to evaluate and refine the rate-setting process and regions.

Behavioral Health

3.6 Behavioral Health Payment Reform

3.6.1 Background

Through realignment efforts in 1991 and 2011, funding for the majority of the non-federal share of costs associated with the specialty mental health and substance use disorder (SUD) services became the responsibility of the counties. Currently, counties are reimbursed for the federal and state portion of costs for services and administration of these programs via Medicaid Certified Public Expenditure (CPE) methodologies. Under

CPE methodologies, reimbursements to counties are limited to costs incurred by the counties and are subject to a lengthy and labor-intensive cost reconciliation process.

For specialty mental health services, counties pay with non-federal funds at the time of service and when incurring costs to administer the programs. The counties then submit CPEs to DHCS so that the state can draw down eligible federal Medicaid matching funds. In accordance with the CMS-approved CPE protocol, mental health plans receive interim reimbursement of federal financial participation on a fee-for-service basis, pursuant to interim rates approved by the state on an annual basis for approved units of service for allowable procedure codes. The state completes the interim reconciliation of interim Medicaid payments no later than 24 months after the close of each state fiscal year. The final cost reconciliation of mental health plan interim Medicaid payments occurs within 36 months after the certified, reconciled, state-developed cost reports are submitted.

The Drug Medi-Cal portions of the State Plan establishes the interim payment methodology for both Narcotic Treatment Program and non-Narcotic Treatment Program services. Generally, this methodology requires an interim reimbursement at the statewide maximum allowable or uniform statewide daily dosing rate. DHCS also provides an interim reimbursement to counties for costs incurred to administer DMC-ODS or DMC programs. After the fiscal year ends, DHCS performs a settlement with counties for the cost of administering the SUD services (either through DMC State Plan or through DMC-ODS). These cost reconciliations occur years after the close of the state fiscal year to allow time for claims run out as well as for DHCS to complete its cost reconciliation audits.

To incentivize additional investment in the delivery systems and reduce overall burden on counties and the state, DHCS is proposing to reform behavioral health payment methodologies for counties. Under the current CPE methodology, counties are not able to retain revenue when implementing cost-reduction efforts, thereby limiting the ability to fully invest in the delivery system to improve access and quality. These reforms will allow not only for more timely review and final payment, but will enable the county behavioral health system, for the first time, to participate in and design true outcomes and value-based reimbursement structures that reward better overall results and quality of life for Medi-Cal beneficiaries.

3.6.2 Proposal

The state is proposing to reform its behavioral health payment methodologies via a multi-phased approach with the goal of increasing available reimbursement to counties for services provided and to incentivize quality objectives. This proposal would move reimbursement for all inpatient and outpatient specialty mental health and substance use disorder services from CPE-based methodologies to other rate-based/value-based structures that instead utilize intergovernmental transfers to fund the county-supplied non-federal share. DHCS proposes to implement the shift in methodology in two initial phases:

- In order to establish appropriate payment rates, DHCS proposes to transition specialty mental health and SUD services from existing Healthcare Common Procedure Coding System (HCPCS) Level II coding to Level I coding, known as Current Procedural Terminology (CPT) coding, when possible; and
- DHCS will establish reimbursement rates, as well as an ongoing methodology for updating rates, for the updated codes with non-federal share being provided by counties via intergovernmental transfer instead of CPEs, eliminating the need for reconciliation to actual costs.

Transition from HCPCS Level II Coding to CPT Coding

DHCS is proposing to transition from existing HCPCS Level II coding to CPT coding in all cases where a suitable CPT code exists. If a suitable CPT code does not exist, DHCS would identify an appropriate HCPCS Level II code.

For specialty mental health services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: therapy, assessments, treatment planning, rehabilitation, prescribing medication, administering medication, patient education, and crisis intervention. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Services that currently receive a bundled rate, such as psychiatric inpatient hospital services, adult residential treatment, crisis residential treatment, psychiatric health facility services, crisis stabilization, day treatment, and day rehabilitation, would continue to be reimbursed using a bundled rate.

For SUD services, DHCS would identify a mix of HCPCS Level II codes and CPT codes for the following service functions: assessment, case management, crisis intervention, discharge planning, group counseling, individual counseling, medical psychotherapy, prescribing medication, administering medication, recovery services, and treatment planning. DHCS would establish a rate for each of the HCPCS Level II codes and CPT codes identified within each service function. Counties would receive payment for each service rendered based upon the rate established for the specific HCPCS Level II code or CPT code. Narcotic Treatment Programs would continue to be reimbursed a daily rate for each encounter.

Rate Setting Methodology

For the establishment of reimbursement rates, DHCS is proposing to set rates by peer grouping. Each peer group would be made up of counties with similar costs of doing business to best reflect local needs. Rates would include a service component as well as an administrative component and a utilization management/quality assurance component, which would be percentages on top of the service component. Additionally,

DHCS is proposing to establish a methodology to provide, at a minimum, an annual update to established rates to ensure that reimbursement continues to reflect the cost of providing services, administration, and required utilization management/quality assurance activities.

To start, DHCS is proposing to process intergovernmental transfers and make payments to counties on a monthly basis. Eventually, DHCS plans to transition to quarterly intergovernmental transfers and payments to reduce the administrative burden tied to processing intergovernmental transfers and payments for 58 counties on a monthly basis. The state will discuss with the counties the appropriate time to transition from monthly to quarterly payments.

3.6.3 Rationale

Under CPE-based methodologies, all reimbursement is limited to the actual cost of providing services, which does not allow for value-based arrangements or incentives to reduce costs and share in the savings. The shift from CPE to intergovernmental transfer-based methodologies will allow DHCS, in collaboration with county partners, to:

- Establish rates for reimbursement that are not limited to cost and instead focus on the quality and value of services;
- Provide more flexibility to counties to explore provider reimbursement arrangements that incentivize quality and value;
- Create opportunities for improved coordination of care by simplifying options for contracts and payments between Medi-Cal managed care plans and counties, without limiting financial benefits for the county; and
- Reduce state and county administrative burden and allow counties to close their accounting records closer to the end of a fiscal year by eliminating the lengthy and labor-intensive cost-reconciliation process.

Finally, the shift from HCPCS Level II coding to HCPCS Level I coding will allow for more granular claiming and reporting of services provided, creating the opportunity for more accurate reimbursement to counties/providers. The shift in coding will also allow counties and DHCS to better report performance outcomes and measures. In turn, the increased reporting will provide counties and DHCS with more accurate, useful information on health care quality to inform policy decisions.

3.7.4 Proposed Timeline

Given the need to ensure county readiness for this change in approach, DHCS is looking forward to working with counties and stakeholders to establish the timeline for adoption of the HCPCS Level I. DHCS proposes to work with counties and stakeholders to evaluate county readiness and develop a strategy to support them in making this transition. However, the earliest date the shift would occur would be July 1, 2022.

The transition from cost-based reimbursement to an established rate schedule would take place concurrently with the adoption of the HCPCS Level I coding. DHCS would, initially, establish separate rate schedules for specialty mental health and substance use disorder services, with the goal of aligning rate schedules when these services are administratively integrated into a single behavioral health managed care program. DHCS would begin the intergovernmental transfer-based reimbursement at the start of a state-county fiscal year to ease the transition.

3.7 Medical Necessity Criteria

3.7.1 Background

Current medical necessity criteria for specialty mental health services are outdated and confusing and can lead to challenges for beneficiaries in accessing appropriate care. Current diagnosis requirements can prevent beneficiaries from receiving urgently needed care, especially for children, who are entitled to care before developing a mental health condition, or for people with a co-occurring substance use disorder whose diagnosis may not be immediately clear. DHCS requirements for provider documentation are confusing and may lead to provider burden and risk of payment disallowance during audits.

Currently, DHCS does not standardize screening practices to determine where a beneficiary should initially seek mental health care. As a result, counties and plans have a variety of approaches to determine where beneficiaries should initially access care, whether with county Mental Health Plans (for specialty mental health services) or with Medi-Cal Managed Care or Fee for Service delivery systems (for beneficiaries not meeting criteria for specialty mental health services). DHCS does not currently standardize how beneficiaries transition across these delivery systems when their status changes, leading to inconsistent practices. In addition, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) protection for beneficiaries under age 21 is inconsistently interpreted and leads to confusion and variation in practice.

3.7.2 Proposal

With the CalAIM initiative, DHCS aims to design a coherent plan to address beneficiaries' needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and improve health outcomes. The goal is to ensure beneficiary access to the right care in the right place at the right time.

In CalAIM, DHCS proposes to update and clarify medical necessity criteria for specialty mental health services for both adults and children, including allowing reimbursement of treatment before diagnosis and clarifying that treatment in the presence of a co-occurring SUD is appropriate and reimbursable when medical necessity is met.

DHCS proposes to clarify EPSDT protections for beneficiaries under age 21, and create criteria for children to access specialty mental health services based on experience of trauma and risk of developing future mental health conditions, such as involvement in child welfare or experience of homelessness.

DHCS proposes to develop a standardized screening tool to facilitate accurate determinations of when care would be better delivered in the specialty mental health delivery system or in the Medi-Cal managed are or fee for service system. In addition, DHCS proposes to develop a standardized transition tool, for when a beneficiary's condition changes, and they would be better served in the other delivery system.

DHCS proposes to implement a "no wrong door" policy to ensure beneficiaries receive medically necessary treatment regardless of the delivery system where they seek care. This policy would allow beneficiaries who directly access a treatment provider to receive an assessment and mental health services, and to have that provider reimbursed for those services, even if the beneficiary is ultimately transferred to the other delivery system due to their level of impairment and mental health needs. In certain situations, beneficiaries may receive non-duplicative services in multiple delivery systems, such as when a beneficiary has an ongoing therapeutic relationship with a therapist or psychiatrist in one delivery system while requiring medically necessary services in the other.

DHCS also proposes to simplify and streamline mental health documentation requirements, to align with medical provider requirements, improve efficiency, and decrease provider burnout.

With respect to inpatient specialty mental health services, DHCS proposes to update the criteria for psychiatric inpatient medical necessity currently provided in Title 9 of the California Code of Regulations. To facilitate improved communication between mental health plans and hospitals, and to decrease variation in clinical documentation requests across counties, DHCS will develop, in consultation with hospital and county stakeholders, documentation standards and concurrent review protocols to allow efficient and streamlined communication of clinical information during concurrent review.

Division of Services Between Mental Health Plans and Medi-Cal Managed Care Plans

To ensure beneficiaries with behavioral health needs are guided to the most appropriate delivery system to address their needs, DHCS is proposing to update its medical necessity criteria and processes, which would be organized as described below:

California provides Medi-Cal mental health services through Managed Care Plans, Fee for Service (FFS), and county mental health plans. The delivery system responsible to provide the mental health service depends on the degree of a beneficiary's impairment from the mental health condition and other criteria described below. Beneficiaries may receive mental health services prior to diagnosis in any of these delivery systems under certain conditions, even if ultimately the beneficiary is determined not to have a mental disorder. Beneficiaries may initiate medically necessary mental health services in one delivery system and receive ongoing services in another system. Beneficiaries whose degree of impairment changes may transition between the delivery systems, or under some circumstances may receive medically necessary mental health services in more than one delivery system. Care shall be coordinated between the delivery systems and services shall not be duplicated.

Medi-Cal Managed Care Plan responsibilities:

The following nonspecialty mental health services are covered by managed care plans:

a) Individual and group mental health evaluation and treatment (including psychotherapy and family therapy);
b) Psychological testing, when clinically indicated to evaluate a mental health condition;
c) Outpatient services for the purposes of monitoring drug therapy;
d) Psychiatric consultation; and,
e) Outpatient laboratory, drugs, supplies and supplements (note: the pharmacy benefit will be carved out of managed care plans contracts and transitioned to fee for service delivery under Medi-Cal Rx as of 4/1/2021).

Medi-Cal managed care plans are responsible to provide the above nonspecialty mental health services to adult beneficiaries with mild to moderate distress or mild to moderate impairment of mental, emotional or behavioral functioning resulting from mental health disorders, as defined by the current Diagnostic and Statistical Manual of Mental Disorders. Managed care plans are also required to provide non-specialty mental health services to children under the age of 21. Managed care plans are also responsible to provide mental health services to beneficiaries with potential mental health disorders

These services are also available in the FFS mental health delivery system for beneficiaries not enrolled in Medi-Cal managed care.

County Mental Health Plan responsibilities:

For beneficiaries 21 years and over, Mental health plans are responsible to provide specialty mental health services for beneficiaries who meet (A) and (B) below:

(A): The beneficiary must have one of the following:

(i) Significant impairment ("impairment" is defined as distress, disability or dysfunction in social, occupational, or other important activities), OR
(ii) A reasonable probability of significant deterioration in an important area of life functioning.

(B): The beneficiary's condition in (A) is due to:

(i) A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), OR

(ii) A suspected mental disorder that has not yet been diagnosed.

For beneficiaries under age 21[1],
Mental health plans are responsible to provide specialty mental health services to beneficiaries who meet either Criteria 1 **or** Criteria 2:

Criteria 1: The beneficiary is at high risk for a future mental health disorder due to experience of trauma, evidenced by: scoring in the high-risk range on a DHCS-approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness.

Criteria 2: The beneficiary must meet both (A) and (B), below:

(A): The beneficiary must have at least one of the following:

I. Significant impairment, or
II. A reasonable probability of significant deterioration in an important area of life functioning, or
III. iii. A reasonable probability a child will not progress developmentally as appropriate, or
IV. Less than significant impairment, but requires mental health services that are not included within the mental health benefits that managed care plans are required to provide.

(B): The beneficiary's condition in (A) is due to:
I. A diagnosed mental health disorder (according to the current Diagnostic and Statistical Manual of Mental Disorders and International Statistical Classification of Diseases and Related Health Problems criteria), or
II. A suspected mental disorder that has not yet been diagnosed.

Mental health plans provide the following specialty mental health services

1. Crisis Residential Treatment Services
2. Adult Residential Treatment Services
3. Crisis Interventions
4. Crisis Stabilization
5. Day Rehabilitation
6. Day Treatment Intensive
7. Medication Support Services
8. Psychiatric Health Facility Services

[1] The Early and Periodic Screening, Prevention and Treatment protection entitles beneficiaries under age 21 to services necessary to correct or ameliorate a mental illness and condition recommended by a qualified provider operating within his or her scope of practice, whether or not the service is in the state plan.

9. Psychiatric Inpatient Hospital Services
10. Targeted Case Management/Intensive Care Coordination
11. Mental Health Services and Intensive Home-Based Services (including the following service interventions: Assessment, Plan Development, Therapy, Rehabilitation, and Collateral)
12. Therapeutic Behavioral Services
13. Therapeutic Foster Care Services

Substance Use Disorder Services

As with the current SMHS medical necessity criteria, the current Section 1115 waiver for SUD services requires beneficiaries to be diagnosed with a SUD to meet criteria for reimbursement, preventing the provision of treatment services prior to a definitive diagnosis.

As for mental health, DHCS proposes that substance use disorder treatment services may be provided and reimbursed prior to the determination of a diagnosis, including providing services to beneficiaries with co-occurring mental health disorders.

In addition, DHCS heard many comments from stakeholders about how to improve the Drug Medi-Cal Organized Delivery System, which are reflected in the "DMC-ODS Program Renewal and Policy Improvements" section of this proposal.

Documentation Requirements for Specialty Mental Health and Substance Use Disorder Services

Documentation requirements for SUD and SMHS are currently stringent. Stakeholders report that concern about disallowances result in providers spending an excessive amount of time "treating the chart instead of treating the patient." With the goal of aligning standards across physical and behavioral health programs, DHCS is proposing to update documentation requirements for specialty mental health and substance use disorder treatment to simplify and streamline requirements. For example, DHCS proposes to eliminate the requirement for a point-in-time treatment plan signed by the client, with progress notes tying to the treatment plan. Evidence does not show that shared decision-making is achieved through signature requirements, and the requirement that every note and every intervention must tie to a treatment plan is inefficient and inconsistent with documentation requirements in the medical (physical health) system. DHCS proposes to align behavioral health and medical documentation requirements in Medi-Cal by requiring problem lists and progress notes to reflect the care given and to align with the appropriate billing codes. DHCS also proposes to revise the clinical auditing protocol, to use disallowances when there is evidence of fraud, waste, and abuse, and to use quality improvement methodologies (such as oversight from the External Quality Review Organization) for minor clinical documentation concerns. These documentation changes will align with behavioral health payment reform, as the use of Level 1 HCPCS codes comes with national documentation standards and expectations.

Technical Corrections

DHCS proposes to make other technical corrections to address outdated references to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), rather than the more current DSM-V, and reflect federal diagnostic coding requirements related to use of International Classification of Diseases (ICD) code sets.

3.7.3 Rationale

Updates to medical necessity criteria for specialty mental health and SUD services, and related policy proposals, are required to achieve more up-to-date clinical practices and better clarity for oversight.

3.7.4 Proposed Timeline

DHCS recommends making changes to the specialty mental health and substance use disorder medical necessity criteria and related processes, as applicable, effective January 1, 2022 with the approval of the Section 1115 and 1915(b) waivers.

3.8 Administrative Integration of Specialty Mental Health and Substance Use Disorder Services

3.8.1 Background

California's mental health plans operate under the authority of a Section 1915(b) waiver, while DMC-ODS plans operate under the authority of a Section 1115 demonstration, and Drug Medi-Cal fee-for-service programs are authorized through California's Medicaid State Plan.

For mental health plans and DMC-ODS plans, DHCS contracts with counties to act as prepaid inpatient health plans to provide, or arrange for the provision of, specialty mental health services and DMC-ODS treatment services to beneficiaries. While the specialty mental health services program is a statewide benefit, the DMC-ODS managed care program is only covered in counties that have "opted-in" and are approved to participate by DHCS and CMS.

Fifty-six mental health plans administer the SMHS program, including two joint arrangements in Sutter/Yuba and Placer/Sierra. For SUD services, 37 counties administer the DMC-ODS program, covering more than 90 percent of the Medi-Cal population. Seven of these counties contract with a local Medi-Cal managed care plan to provide an alternative regional model for DMC-ODS. The remaining 21 counties provide SUD treatment services through Drug Medi-Cal.

Medi-Cal specialty mental health and SUD treatment services are currently administered through separate, unique structures at the county level. Beneficiaries with co-occurring mental health and SUD treatment needs must navigate multiple systems to access care.

Beneficiaries must review multiple handbooks and provider directories, navigate separate intake and assessment processes, and often travel to multiple locations to receive care. Counties and providers face challenging documentation and coding requirements, especially for beneficiaries with both SUDs and mental health conditions.

At the system level, counties must demonstrate compliance with two sets of requirements and are subject to multiple reviews. For DMC-ODS counties, administering two distinct prepaid inpatient health plans must demonstrate compliance with federal managed care requirements twice, essentially running two almost entirely separate managed care programs with duplicative processes for quality improvement and performance measurement, beneficiary appeals, and program integrity.

3.8.2 Proposal

DHCS is proposing administrative integration of specialty mental health and SUD services into one behavioral health managed care program. This proposal is distinct from the Full Integration Plan which will integrate physical, behavioral and oral health care into comprehensive managed care plans. The goal is to improve outcomes for beneficiaries through coordinated treatment across the continuum of care. An additional goal and benefit would be to reduce administrative and fiscal burdens for counties, providers, and the state.

For counties participating in DMC-ODS managed care, DHCS is interested in working toward integrating the two behavioral health programs/prepaid inpatient health plans into a single behavioral health plan structure. The result would be a single prepaid inpatient health structure in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD treatment services for all Medi-Cal beneficiaries in that county or region. Participating counties would benefit from streamlined state requirements and the elimination of redundancy. Consolidating operations and resources into one behavioral health managed care plan would allow counties to successfully meet state and federal requirements and significantly decrease their administrative burden.

Additionally, Drug Medi-Cal fee-for-service counties will also be able to integrate such services; however, slight variations may apply due to the differences of federal requirements for fee-for-service verses prepaid inpatient health plans.

Clinical Integration

1. Access Line

Counties are required to have a 24-hour access line for mental health plans and for DMC-ODS. Some Drug Medi-Cal counties may also have 24-hour access lines, although it is not a requirement. Many counties already use their access lines in an integrated manner to triage, screen, and refer beneficiaries for both specialty mental

health and SUD treatment services; however, some counties maintain separate lines. Under an integrated model, the goal would be for all counties to have an integrated, 24-hour access line for beneficiaries seeking either specialty mental health and/or SUD services.

2. Intake/Screening/ Referrals

Processes for intake, screening, and referral vary by county. Optimally, counties would have standardized and streamlined intake processes that are timely, emphasize a positive beneficiary experience, and use a "no wrong door" approach to help beneficiaries access mental health and substance use disorder services. While assessments are performed by clinicians and tailored to the needs of the client, and may vary based on setting, DHCS proposes to move forward with a standardized statewide screening tool for beneficiaries 21 and over, and one for beneficiaries under 21, to ensure beneficiaries receive prompt care in the right delivery system.

3. Assessment

Assessment processes and tools for specialty mental health and SUD services also vary by county. For example, the American Society of Addiction Medicine placement tool is used to make level of care determinations DMC-ODS. However, an assessment tool is not required in Drug Medi-Cal counties. For SMHS, the Child and Adolescent Needs and Strengths tool is required for children and youth; however, there is not a required tool for adults. More research will be needed to determine which aspects, authorities, or requirements need to be addressed to integrate clinical assessments for mental health and SUDs.

4. Treatment Planning

Currently, treatment planning for specialty mental health and SUD treatment services is conducted separately and is not integrated. Beneficiaries receiving both types of services can have multiple treatment plans that include different documentation requirements. To improve efficiency, counties would integrate treatment planning for both specialty mental health and substance use disorder services with simplified and aligned documentation requirements. The goal would be to develop a new, simplified, more client-centered and strength-based approach to behavioral health treatment planning and to align treatment planning and documentation standards with physical health care. Additionally, DHCS will provide counties with relevant Medi-Cal services data, which may include managed care encounter and pharmacy claims data, to allow for better coordination of care and treatment planning.

5. Beneficiary Informing Materials

Currently, beneficiaries who receive services through mental health plans and DMC-ODS receive two beneficiary handbooks. The handbooks are not the same, but both

address elements that are required by federal managed care regulations, such as language regarding the grievance, appeals and state fair hearing processes. The goal is to consolidate beneficiary information materials to streamline them into one user-friendly handbook, reduce confusion, increase access, and achieve administrative efficiencies.

Consideration would need to be given to implementing this element in Drug Medi-Cal counties, since they are not currently required to have a beneficiary handbook.

Administrative Integration

1. Contracts

Currently, there are three separate contract types between DHCS and counties: mental health plans, DMC-ODS and Drug Medi-Cal counties. Under an integrated system, the goal would be to have only one contract in every county that would cover both all Medi-Cal specialty mental health and SUD treatment services.

2. Data Sharing / Privacy Concerns

Counties are responsible for managing data-sharing at two levels: within and across county plans, and at the provider level. Data sharing and privacy concerns need to be explored to determine what areas can be addressed, since there are different considerations and regulations pertaining to data sharing for SMHS and SUD services. Addressing these concerns will be critical in determining whether and when counties can integrate assessments, treatment plans, and electronic health records, among other processes. A thorough assessment of the various barriers and solutions to stringent patient privacy protections will be required. There will need to be a thorough assessment by the state and counties to identify the various barriers and solutions to stringent patient privacy protections built into federal regulations.

3. Electronic Health Record Integration and Re-Design

Many counties currently operate separate electronic health records (EHRs) or maintain differently configured and separate records for specialty mental health and substance use disorder services. This is largely in response to federal regulations, but also due to historical bifurcation of the two programs and different documentation and data-reporting requirements for the specialty mental health and substance use disorder programs. Timelines for integrating different components of administrative integration will depend on counties' ability to arrive at a record design that is compliant and then collaborate with their vendors to make multiple, timely modifications to their electronic health records.

4. Cultural Competence Plans

Mental health plans are required to have a plan for culturally responsive care for specialty mental health services. DMC-ODS plans are also required to have a culturally responsive care plan. Under an integrated system, counties would have only one integrated plan for culturally responsive care instead of two, separate plans.

Considerations would need to be given to how this element would be implemented in Drug Medi-Cal counties since they are currently not subject to these same requirements.

Integration of DHCS Oversight Functions

1. Quality Improvement

Some counties have integrated quality improvement and performance measurement programs for specialty mental health and substance use disorder services. However, most programs – or components of them – are still separate. Under an integrated system, counties would develop and operationalize a consolidated quality improvement plan, have a single quality improvement committee, and develop a comprehensive list of performance measures for specialty mental health services and substance use disorder services.

2. External Quality Review Organizations

Pursuant to federal Medicaid managed care requirements, an external quality review is required for both mental health plans and DMC-ODS. Currently, Behavioral Health Concepts is the contractor that acts as the External Quality Review Organization for both programs. However, there are separate contracts, review processes, timelines, and protocols. In addition, counties must develop separate performance improvement plans for each program. The goal is to implement a combined external quality review process, which would result in one external review and integrated performance improvement plans, and ultimately having one single External Quality Review Organization (EQRO) report for each county. Since an external quality review is not required for Drug Medi-Cal counties, further exploration will be needed to determine the extent to which these elements would play a role under an integrated model.

3. Compliance Reviews

Current compliance reviews conducted by DHCS for mental health plans, DMC-ODS, and Drug Medi-Cal counties are separate. Under an integrated model, the goal would be to consolidate compliance reviews into a single review with an integrated protocol. A particular focus of this effort will be on streamlining documentation requirements for behavioral health providers to allow integrated behavioral health care.

4. Network Adequacy

Network adequacy certification processes are separate for specialty mental health plans and DMC-ODS. Under an integrated model, DHCS would certify one network for specialty mental health and substance use disorder managed care services for each county, instead of certifying two networks as currently required.

5. Licensing & Certification

Existing requirements and processes for licensing and certification are different and separate for specialty mental health and substance use disorder providers. The goal is to streamline licensing and certification requirements, processes, and timeframes across the behavioral health managed care system, where appropriate. Successful implementation of integrated care models would also necessitate a discussion on non-administrative changes that may be needed, such as workforce development, cross-training of existing providers, and adoption of new evidence-based practices.

3.8.3 Rationale

About half of individuals with a SMI have a co-occurring substance use and those individuals benefit from integrated treatment. Since the state provides Medi-Cal-covered substance use disorder and specialty mental health services through two separate county-operated delivery systems, it is difficult for counties to provide integrated treatment to individuals who have co-occurring disorders. For example, counties with both DMC-ODS and mental health plans are subject to two separate annual quality assessments, two separate post-payment chart audits, and two separate reimbursement and cost reporting methods. The purpose of this proposal is to make changes to streamline the administrative functions for SUD and SMHS.

3.8.4 Proposed Timeline

The goal would be to submit for a single, integrated behavioral health plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and SUD services under the next 1915(b) waiver in 2027. Both state-level and county-level activities will be required to achieve this goal. Successful implementation will require careful sequencing and planning and a phased-in approach where cohorts are considered.

3.9 Behavioral Health Regional Contracting

3.9.1 Background

State law allows two or more counties acting jointly to deliver or subcontract for the delivery of specialty mental health services. Furthermore, participating DMC-ODS counties are permitted to develop regional delivery systems for required modalities or to act jointly to deliver covered services, with approval from DHCS and CMS, as applicable.

3.9.2 Proposal

DHCS encourages counties to develop regional approaches to administer and deliver specialty mental health and substance use disorder services to Medi-Cal beneficiaries. There are a variety of options available to counties, including a Joint Powers Authority to operate such services for a multi-county region (e.g., Sutter/Yuba). Counties could also pool resources to contract with an administrative services organization/third-party administrator or other entity, such as the County Medical Services Program or the local Medi-Cal managed care plan, to create administrative efficiencies across multiple counties.

Small counties, rural/frontier counties, and counties with shared population centers or complementary resources should consider opportunities for regional partnership. DHCS is interested in discussing how counties not currently seeking DMC-ODS participation may be more interested in doing so through a regional approach and/or how services provided under Drug Medi-Cal might also be provided through a regional approach. DHCS is committed to working with counties to offer technical assistance to help develop regional contracts and establish innovative partnerships.

3.9.3 Rationale

Acting jointly through regional contracts would allow counties to pool their resources, which can improve access and availability of services for Medi-Cal beneficiaries in their region and allow for increased county administrative efficiencies. Although regional contracting is currently allowed under state law, only a few counties have taken advantage of this opportunity. Regional contracting would give counties opportunities to share workforce and jointly invest in administrative infrastructure such as electron health records, billing and claiming systems, and oversight/quality assurance and improvement.

Regional contracts offer numerous potential advantages. For example, network adequacy certification requires significant administrative infrastructure to develop and maintain policies and procedures for tracking network resources, and counties must identify and contract with additional qualified providers when network gaps are identified. Both functions (tracking and finding new providers) can prove challenging in some counties that may have fewer local providers. Through regional contracts, counties could reduce duplication and standardize administrative processes, such as beneficiary handbooks, provider directories, and grievance and appeal processes.

For Drug Medi-Cal counties, regionalization could potentially enable smaller counties to participate in DMC-ODS, providing a broader set of services to their residents when it would not be otherwise feasible. By participating in DMC-ODS, these counties could then create a single, integrated behavioral health plan, as described in the CalAIM Administrative Integration of Specialty Mental Health and Substance Use Disorder Services proposal.

In addition, Medi-Cal managed care plans, mental health plans, and DMC-ODS plans must meet the full array of state and federal requirements applicable to prepaid inpatient health plans under the federal Medicaid managed care regulations. Among these are network adequacy, quality assessment and performance improvement, beneficiary rights and protections, and program integrity. For individual counties, entering into regional contracting agreements would reduce the administrative burden of meeting Medicaid managed care requirements. Counties could better utilize resources to focus on improving access, quality of care, and beneficiary outcomes, while mitigating the risk of audit exceptions and administrative and financial sanctions.

3.9.4 Proposed Timeline

DHCS seeks input from county partners and other stakeholders regarding an estimated timeframe for establishing regional contracting agreements.

3.10 Drug Medi-Cal Organized Delivery System Renewal and Policy Improvements

3.10.1 Background

One of the key goals of the Drug Medi-Cal Organized Delivery System (DMC-ODS) was to treat more people more effectively by reorganizing the delivery system for substance use disorder (SUD) treatment through Medi-Cal. California's Drug Medi-Cal Organized Delivery System (DMC-ODS) was the nation's first SUD treatment demonstration project under Section 1115, approved by CMS in 2015. Since then, more than 20 other states have received approval for similar substance use disorder treatment demonstrations. The program has established a continuum of care modeled after the American Society for Addiction Medicine (ASAM) criteria. These criteria are the most widely used and comprehensive set of guidelines for placement, continued stay, and transfer/discharge of patients with addiction.

The benefits under the DMC-ODS, which counties administer as pre-paid inpatient health plans (PIHPs), include all of the standard SUD treatment services covered in California's Medicaid State Plan (outpatient, intensive outpatient, perinatal residential, narcotic treatment programs and naltrexone), plus case management, multiple ASAM levels of residential substance use disorder treatment, withdrawal management services, recovery services, physician consultation and if the county chooses, additional medication assisted treatment, and partial hospitalization.

Also included in the current program is the expenditure authority to allow federal Medicaid reimbursement for short-term residential SUD treatment stays in an Institution for Mental Disease (IMD). The IMD exclusion has historically prohibited federal reimbursement for residential and inpatient mental health and SUD treatment for Medicaid enrollees age 21-64, in facilities with more than 16 beds. This exclusion deterred most providers in the State who found it financially unviable to operate facilities with so few beds. Allowing for reimbursement of residential SUD treatment services through the Medi-Cal program, with

no limitation on the number of beds, means that counties can receive federal matching funds for services that were previously unavailable.

Currently, DMC-ODS is not a statewide benefit since the program operates only in counties that "opt in" to participate and are approved to do so by both DHCS and CMS. There are currently 37 counties participating in the DMC-ODS demonstration, providing access to SUD treatment services for 96 percent of the Medi-Cal population. Seven of these counties are working with a local managed care organization to implement a regional model. Medi-Cal beneficiaries in the 21 counties not participating in the program provide their SUD treatment services through fee-for-service as authorized through the Drug Medi-Cal State Plan. The fee-for-service benefit is more limited than the DMC-ODS benefit in terms of covered services and that it is not a managed care program.

3.10.2 Proposal

DHCS proposes to update and improve the DMC-ODS, based on experience from the first several years of implementation. Accordingly, DHCS proposes to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency.

DHCS aims to design a cohesive plan to address beneficiaries' SUD treatment needs across the continuum of care, ensure that all Medi-Cal beneficiaries receive coordinated services, and to promote long-term recovery. This requires developing new approaches to care delivery and system administration that will improve the beneficiary experience, increase efficiency, ensure cost-effectiveness, and achieve positive health outcomes.

The 37 counties that have implemented the DMC-ODS have made tremendous strides in improving the continuum of care for Medi-Cal beneficiaries with SUD treatment needs. Implementation across 37 California counties has also yielded lessons learned and opportunities to clarify or change policies to support the goal of improved beneficiary care and administrative efficiency. DHCS also acknowledges that for many counties, the DMC-ODS model of care is still very new since implementation was phased in over several years.

Accordingly, DHCS solicited input from stakeholders on the following proposed policy clarifications and changes, which have been thoughtfully constructed to balance system improvements while minimizing disruptions at the local level.

DHCS also intends to provide counties with another opportunity to opt-in to participate in the DMC-ODS in hopes of promoting DMC-ODS participation across the state. While participation in DMC-ODS will not be mandatory for counties, DHCS would like to work with counties not currently participating in the DMC-ODS to explore ways to encourage the remaining counties to opt-in.

Residential Treatment Length-of-Stay Requirements

Currently, within a 365-day period, adult residential SUD treatment services may be authorized for two non-continuous stays, for up to 90 days for each stay, with one 30-day extension permitted for one of the stays. Similarly, within a 365-day period, adolescent residential treatment services may be authorized for two non-continuous stays; however, stays for adolescents are limited to 30 days each stay, with one up to 30-day extension allowed for one of the stays.

Residential length-of-stay should be determined based on the individual's condition, medical necessity, and treatment needs. Given that the two-episode limit is inconsistent with the clinical understanding of relapse and recovery from SUDs, DHCS proposed in the 12-month extension request to remove this limitation and base treatment on medical necessity.[2] DHCS will further propose that there be no distinction between adults and adolescents for these particular requirements.

Note: DHCS must obtain approval from CMS regarding all components of the Section 1115 extension and renewal. CMS is currently only approving SUD 1115 demonstrations with a residential benefit average length-of-stay of 30 days. While some states may show average lengths of stay that are close to the 30-day target, these are likely to include numerous treatment episodes that may have terminated prematurely, before the client achieved positive clinical outcomes. Including these shorter stays in the calculation may lower the average and give the impression that shorter lengths of stay are universally feasible and appropriate.

As such, DHCS will examine the possibility of tracking and documenting the average length-of-stay for only those DMC-ODS enrollees that achieve positive treatment outcomes. Furthermore, with the substantial rise in methamphetamine usage and overdose deaths in California, DHCS will work closely with CMS to negotiate a residential treatment benefit that accounts for the increased clinical needs of individuals utilizing stimulants.

[2] Proposed changes to the DMC-ODS program included in the Medi-Cal 2020 12-month extension request: 1) Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period, 2) Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis, 3) Clarify that recovery services benefit, 4) Expand access to MAT, and 5) Increase access to SUD treatment for American Indians and Alaska Natives.

Residential Treatment Definition

The current definition of residential treatment in California does not clearly define the amount, duration, and scope of covered services, and there are different treatment standards and limitations for adults and adolescents.

DHCS proposes that the definition of residential treatment be updated to remove the adolescent length-of-stay limitations, and to add mandatory provisions for referral to medication assisted treatment. DHCS would also propose to remove the distinction between adults and adolescents for these requirements, with the exception of Early and Periodic Screening, Diagnostic, and Treatment services.

Recovery Services

As part of Dimension 6 (Recovery Environment) of the ASAM criteria, during the transfer/transition planning process, beneficiaries shall be linked to applicable recovery services. Beneficiaries may access recovery services after completing their course of treatment whether they are triggered, have relapsed, or as a preventive measure to avoid relapse.

DHCS proposed in the 12-month extension to clarify the following policies related to recovery services:

- Specify the services included in the benefit (e.g., group, education sessions, and assessment);
- Establish when and how beneficiaries may access these services, including language to encourage the use of recovery services for justice-involved individuals: and
- Define the term “after completing their course of treatment,” to not inadvertently prohibit beneficiaries receiving long-term medication assisted treatment from having access to recovery services.

If these proposed changes are not ultimately approved in the 12-month extension, they will be included in the demonstration renewal request that DHCS will submit in 2021, for a five year renewal from January 1, 2022-December 31, 2026.

Additional Medication Assisted Treatment

Counties are required to cover opioid treatment program services, also called Narcotic Treatment Programs. Currently counties may elect to cover additional medication assisted treatment, which includes the ordering, prescribing, administering, and monitoring of all medications for SUD treatment.

DHCS proposed in the 12-month extension request to keep the additional medication assisted treatment (MAT) services as an optional benefit but clarified the coverage provisions to require that all substance use disorder managed care providers demonstrate that they either directly offer, or have referral mechanisms to medication assisted treatment. The goal is to have a county-wide multi-delivery system of coverage.

Clinician Consultation Services

Currently, physician consultation services cover time spent by the DMC-ODS physicians consulting with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists. The name of the benefit will change to Clinician Consultation Services and be expanded to include consultation services for, and by, licensed clinicians including Nurse Practitioners and Physician Assistants. Coverage of consultation services is designed to help clinicians seek expert advice on designing treatment plans for beneficiaries. Clinician consultation services can only be billed and reimbursed by providers in DMC-ODS provider sites.

DHCS proposes to clarify the terms of clinician consultation, particularly with regard to how and who can claim this activity. DHCS proposes to remove the limitation that clinician consultation services can only be billed by certified Drug Medi-Cal providers. Counties may contract with SUD clinicians not certified by Drug Medi-Cal. DHCS' telehealth policy will be used to guide this effort.

Evidence-Based Practice Requirements

Currently, providers are required to implement at least two of the following evidence-based treatment practices based on a timeline established in the county implementation plan: Motivational Interviewing, Cognitive Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho Education. The two evidence-based practices are a per-provider per-service modality.

DHCS proposes to retain the five (5) current evidence-based practices and add Contingency Management to the renewal proposal. Providers are not limited to providing only the six evidence-based practices.

DHCS Provider Appeals Process

Following a county's protest procedure, a provider may currently appeal to DHCS if it believes that the county erroneously rejected the provider's solicitation for a contract.

DHCS proposes removing this process from as it is convoluted, has rarely been used, and it is already addressed by the network adequacy requirements. All providers have a right to appeal under the federal 438 requirements.

Tribal Services

DHCS proposed in the 12-month extension to take several actions to increase access to SUD treatment for American Indians and Alaska Natives, including:

- Providing an allowance for specific cultural practices for Tribal 638 and Urban clinics, reimbursement, and definitions of scope of practice for the workforce of traditional healers and natural helpers, and culturally specific evidence-based practices.

- Requiring Indian health care providers to use at least two evidence-based practices as defined in the DMC-ODS and/or from a list developed by DHCS in consultation with Tribal and Urban partners.

These changes are requested to ensure American Indians and Alaska Natives have access to culturally appropriate and evidence-based substance use disorder treatment.

Treatment after Incarceration

The current language requiring the ASAM criteria, may be underestimating the level of care necessary to serve individuals being released from incarceration, since their substance use was either not possible during incarceration or because individuals under parole/probation supervision are likely hesitant to admit to substance use.

Because inmates are at a high risk of relapse and overdose upon release from incarceration, whether or not there was active use in the last 12 months, DHCS plans to clarify access language for individuals leaving incarceration who have a known substance use disorder.

Billing for Services Prior to Diagnosis

Currently, counties may not begin billing for SUD services until a beneficiary has been diagnosed (i.e., counties may not bill for time spent conducting substance use disorder assessments). Since it takes time for clinicians to evaluate a beneficiary for a substance use disorder, and sometimes presenting symptoms are due to a combination of mental illness, substance use disorder, or both, DHCS proposed in the Medi-Cal 2020 extension to clarify the waiver Special Terms and Conditions to allow reimbursement for SUD assessments (even if it takes multiple visits) before a final diagnosis is determined, which aligns with requirements around assessments for specialty mental health services.

Medical Necessity for Narcotic Treatment Programs (NTPs)

DHCS proposes to update and align the STCs with best practices to allow a physician's history and physical to determine medical necessity for NTP services as required by

federal licensing laws. In addition, DHCS would clarify requirements for the initial assessment and medical necessity determinations in other settings.

Early Intervention (Level 0.5)

DHCS proposes to add ASAM 0.5 level of care for beneficiaries under 21, to allow early intervention as an organized service that may be delivered in a wide variety of settings. This service is designed to explore and address problems or risk factors related to substance use, and to help the individual recognize the harmful consequences of high-risk substance use. This includes engagement activities (including screening, assessment, brief interventions such as motivational interviewing and counseling) for beneficiaries at high-risk for developing substance-related or addictive behavior problems, or those for whom there is not yet sufficient information to document a substance use disorder.

3.10.3 Proposed Timeline

The following changes would go into effect on January 1, 2021, subject to federal approval of the Medi-Cal 2020 12-month extension request:

- Remove the limitation on the number of residential treatment episodes that can be reimbursed in a one-year period
- Clarify that reimbursement is available for SUD assessment and appropriate treatment even before a definitive diagnosis
- Clarify that recovery services benefit
- Expand access to MAT
- Increase access to SUD treatment for American Indians and Alaska Natives.

The remaining changes outlined above would go into effect January 1, 2022, subject to federal approval.

Dental

3.11 New Dental Benefits and Pay for Performance

3.11.1 Background

DHCS is committed to improving the accessibility of Medi-Cal dental services and improving oral health outcomes for Medi-Cal members. To demonstrate that commitment, three initiatives and policy changes have been implemented in recent years:

- The Dental Transformation Initiative under the current Medi-Cal 2020 Section 1115 demonstration;

- Proposition 56 supplemental provider payments; and

- Restoration of the optional adult dental benefit under Medi-Cal.

These efforts have been successful in increasing preventive dental service utilization for children, as well as increasing adult utilization of dental care. While two of the initiatives share a common theme – financial incentives for positive outcomes – they are time-limited. DHCS has included a chart (see **Appendix H: Dental in Proposition 56 vs. CalAIM**) that reflects the dental codes with financial incentives available under CalAIM and Proposition 56.

3.11.2 Proposal

The Department set a goal to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children. In order to progress toward achieving that goal and based on lessons learned from the Dental Transformation Initiative, DHCS proposes the following reforms for Medi-Cal dental be made statewide provide better care and align with national dental care standards. The proposed new benefits include:

- Caries Risk Assessment Bundle for young children; and
- Silver Diamine Fluoride for young children; and specified high-risk and institutional populations; and
- Expanded pay-for-performance initiatives that a) reward increasing the use of preventive services and b) reward establishing/maintaining continuity of care through a dental home. These expanded initiatives would be available statewide for children and adult enrollees.

These expanded initiatives would be available statewide for children and adult enrollees.

New Dental Benefits

DHCS proposes adding coverage of a Caries Risk Assessment Bundle for children ages 0 to 6 years. The Caries Risk Assessment bundle would include nutritional counseling (D1310) to educate and influence behavior change. Based on risk level associated with each individual Medi-Cal beneficiary ages 0 to 6, the benefit would allow the following frequency of services:

- Low – comprehensive preventive services 2x/year (D0601)
- Moderate – comprehensive preventive services 3x/year (D0602)
- High – comprehensive preventive services 4x/year (D0603)

Additionally, DHCS proposes to add coverage of Silver Diamine Fluoride for children ages 0 to 6 years and persons with underlying conditions such that nonrestorative caries treatment may be optimal, which may include adults living in a Skilled Nursing Facility/ Intermediate Care Facility (SNF/ICF) or part of the Department of Developmental Services (DDS) population. The Silver Diamine Fluoride benefit would provide two visits per member per year, for up to ten teeth per visit, at a per tooth rate and a maximum of four treatments per tooth.

Pay for Performance

To increase statewide preventive service utilization for children and adults, DHCS is proposing to provide a flat rate performance payment for each paid preventive service rendered by a service office location.

Additionally, the state proposes to provide an annual flat rate performance payment to a dental service office location that maintains dental continuity of care by establishing a dental home for each patient and perform at least one annual dental exam/evaluation (D0120/D0150/D0145) for two or more years in a row.

3.11.3 Rationale

These policy proposals align with the legislature's charge to achieve at least a 60 percent dental utilization rate for Medi-Cal eligible children, CMS Oral Health Initiative goals for Medicaid (increase by ten percentage points the proportion of Medicaid and CHIP children ages one to 20 who receive a preventive dental service), and our lessons learned from the Dental Transformation Initiative (DTI).

For example, in the DTI - Domain 1, incentive payments were made to service office locations that increased the utilization of the top eleven preventive services available to children. As a result, not only has utilization of preventive services continued to increase year after year, but since the baseline year of 2014, the number of services has increased eight percent and the number of services per member has also increased by seven percent.

Furthermore, data comparing a control group of children in Dental Transformation Initiative counties who did not receive Caries Risk Assessment with children who did receive Caries Risk Assessment over two calendar years yielded staggering results. The Medi-Cal children who had a Caries Risk Assessment received over 300 percent more preventive services compared to 189 percent for non-Caries Risk Assessment children. Additionally, in this same period, the number of restorative services was almost half that of the control group. Medi-Cal children receiving Caries Risk Assessment had a 263 percent increase in restorative services while the control group with no Caries Risk Assessment had a 475 percent increase in restorative services.

3.11.4 Proposed Timeline

DHCS is currently evaluating a timeline for implementation as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration.

County Partners

3.12 Enhancing County Eligibility Oversight and Monitoring

3.12.1 Background

The implementation of the Affordable Care Act (ACA) marked a monumental overhaul of the Medi-Cal program by financing a coverage expansion to populations that previously did not qualify, in addition to streamlining eligibility requirements for some populations. County social service agencies strived to acclimate to the vast changes in regulations while managing an unprecedented surge in Medi-Cal applications submitted statewide. To afford counties the opportunity to modify business processes to effectively administer the Medi-Cal program post Affordable Care Act, counties were held harmless by DHCS for performance standards.

Federal, state, and DHCS audits of Medi-Cal eligibility determinations conducted since the implementation of the Affordable Care Act in 2014 have identified several issues that must be addressed and resolved. Audit findings include performance issues related to timeliness of application processing and timeliness of annual eligibility renewal processing. Discrepancies between the Medi-Cal Eligibility Data System (MEDS), and the county Statewide Automated Welfare System (SAWS) also resulted in audit findings, which in part were caused by system-related issues connected to the implementation of the California Healthcare, Eligibility, Enrollment and Retention System (CalHEERS).

Audit findings, recommendations, and corrective action plans imposed upon DHCS require the State to implement additional oversight activities needed to increase the administrative integrity of the Medi-Cal program. Federal audit findings have also levied fiscal penalties upon DHCS, requiring the state to repay the federal matching funds that were claimed because of erroneous Medi-Cal eligibility determinations.

3.12.2 Proposal

DHCS recommends a phased-in approach to working with the counties to increase program integrity with respect to eligibility and enrollment.

- **Reinstate County Performance Standards**: In response to audit findings, DHCS will reinstate the county performance standards required under state law as a means of addressing and correcting error rates and issues which may have a future impact on the timeliness and accuracy of Medi-Cal eligibility determinations. DHCS plans to implement a series of oversight programs throughout the course of the next 24 months. This includes the implementation of a statewide MEDS alerts monitoring program.

- **Develop an Updated Process for the Monitoring and Reporting of County Performance Standards**: In collaboration with CWDA, SAWS and the counties, DHCS will define roles, responsibilities, and develop an updated written process for the monitoring and reporting of the existing county eligibility performance standards. This process will clearly outline DHCS' performance expectations, taking into consideration the issues that are beyond the counties' control, but including potential consequences if standards are not met.

- **Ensure DHCS/County Partnership through Regular Meetings and Open Lines of Communication:** DHCS will work collaboratively with CWDA, counties, and SAWS to develop a communications plan that articulates a process for receiving and responding to county requests for technical guidance and assistance as necessary and appropriate to support counties through this transition. DHCS will look at leveraging existing meetings, and/or developing dedicated meetings to further open lines of communication related to county oversight and monitoring. DHCS will continue to encourage county feedback in identifying gaps or needed clarifications in policy guidance and automation issues. DHCS will also work closely with counties, SAWS and CalHEERS to identify and pursue needed automation changes to support counties in the effective administration of the Medi-Cal program.

- **Develop a Tiered Corrective Action Approach**: DHCS will work with county partners to establish a tiered corrective action approach that would require the submission of a Corrective Action Plan for counties that do not meet established performance expectations. DHCS remains committed to supporting counties and providing timely policy guidance, along with technical assistance, as needed, in addressing and correcting error trends.

- **Incorporate Fiscal Penalties as Part of the Tiered Corrective Action Approach**: For counties that do not demonstrate sufficient improvement in performance, DHCS will take disciplinary action that could range from technical assistance to requiring corrective action plans to imposing financial penalties on counties that fail to show significant improvement and/or are unresponsive to CAPs.

- **Incorporate Findings/Actions in Public Facing Report Cards**: DHCS will work with CWDA, counties and the SAWS to further develop county performance reports that are publicly posted on the California Health and Human Services (CHHS) Open Data Portal and increase accountability by issuing annual public-facing report cards to all 58 counties.

3.12.3 Rationale

This proposal is envisioned to be a crucial step toward achieving DHCS' larger vision for CalAIM by ensuring Medi-Cal enrollment processes are applied in a standardized and consistent manner statewide. This proposal will help to improve DHCS' oversight and monitoring of various aspects of Medi-Cal eligibility and enrollment and the activities of its contracted partners. This includes implementing additional county oversight activities to increase the integrity of the administration of the Medi-Cal program, as well as implementing the recommendations of the California State Auditor's Office. This proposal will also ensure that DHCS is compliant with federal and state requirements.

3.12.4 Proposed Timeline

Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

- **June 1 – August 31, 2021**: DHCS will reinstate County Performance Standards, including incorporation of MEDS alert monitoring statewide.

- **September 1 – December 30, 2021:** DHCS will develop and publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CAPs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties.

- **January 1 – March 31, 2022:** DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.

- **April 1 – June 30, 2022:** DHCS will implement the county performance monitoring dashboard (a public facing report card). The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.

- **July 1 – September 30, 2022:** DHCS will begin publishing the county performance monitoring dashboard on the CHHS Open Data Portal.
- **July 1 – December 31, 2023:** DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.

3.13 Enhancing County Oversight and Monitoring: CCS and CHDP

3.13.1 Background

The California Children's Services program serves as a proxy of Medi-Cal for case management services and provides diagnostic and treatment services, physical and occupational therapy services to children and youth with eligible medical conditions. The Child Health and Disability Prevention program delivers periodic health assessments and services to low-income children and youth; and provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services.

California Children's Services and Child Health and Disability Prevention beneficiaries are best served when their care is delivered in a standardized and consistent manner. It is the State's responsibility to ensure that the same high-quality standard of care is compliant with federal and State guidelines for all beneficiaries. To remain proactive with emerging trends, technology, medical advances, and interventions, it is essential the State continue to evolve its efforts accordingly.

3.14.2 Proposal

DHCS intends to provide enhanced monitoring and oversight of all 58 counties and three (3) cities (Berkeley, Pasadena, and Long Beach) to ensure continuous, and unwavering optimal care for children. To implement the enhanced monitoring and oversight of California Children's Services and Child Health and Disability Prevention in all counties, DHCS will develop a robust strategic compliance program. Effective compliance programs begin with ascertainable goals, performance measures, and metrics capturing all federal and State requirements. Ongoing quality assurance and data reviews are fundamental to ensuring compliance and continued improvements in program operations and beneficiary care.

Initial efforts will entail a review of all current standards and guidelines for both programs. Once the internal policy review is complete, DHCS will develop initial auditing tools to assess current county/city operations and compliance. DHCS will then evaluate and analyze the findings gathered during audits to identify gaps and vulnerabilities across the State within the programs. The information gathered will be the cornerstone for future efforts, and the basis for the development of the strategic compliance program.

County/City variances in program operations and compliance with federal and State laws are also identified by tracking trends. DHCS will refine and update oversight policies and procedures and implement best practices. DHCS, along with input from our county partners and other stakeholders, will establish goals, metrics, performance measures, and milestones to ensure counties/cities are providing the necessary provider oversight and medical/ dental care for beneficiaries. DHCS will provide training and technical assistance with internal and external partners to achieve statewide consistency of the compliance requirements and goals. In addition, DHCS will conduct ongoing quality assurance reviews, develop, and create county/city program specific dashboards, as necessary to meet internal and external reporting needs.

In alignment with technology trends, the State plans to shift counties/cities from annual hardcopy submission of Plan and Fiscal Guidelines budgets to a more efficient and streamlined automated electronic submission process. Training and overview of the electronic submission process conducted for the counties ensures understanding prior to implementation of the automated system. More rigorous annual review of all county budgets will further efficiencies, contain costs, and improve outcomes.

To better manage this population's health care and ensure targeted interventions are implemented, each county/city and state will enter into a Memorandum of Understanding (MOU) with DHCS. The MOU, in conjunction with other supportive policies (information notices, numbered letters, etc.), will detail how the state will monitor county/city activities, policies and procedures, conduct audits, and implement corrective action plans. This MOU will be developed utilizing information obtained during the audits with the intent of having signed agreements with all counties/cities.

After initial deployment of the enhanced monitoring and oversight, DHCS will continue to conduct ongoing audits, stay proactive with emerging developments, and monitor trends to ensure high-quality consistent care. DHCS will allow sufficient time for counties to implement and adjust to this new structure prior to engaging in any sort of progressive action. DHCS will continue compliance oversight to preserve and improve the overall health and well-being of these vulnerable populations.

3.13.3 Rationale

Enhancing monitoring and oversight will eliminate disparities in care to beneficiaries and reduce vulnerabilities to the state, thereby preserving and improving the overall health and well-being of California's vulnerable populations.

3.13.4 Proposed Timeline

- **Phase I: August 2020 – June 2021**
    - Review of current standards, policies, and guidelines

  - Development of goals, performance measures, and metrics
  - Revision of current Plan and Fiscal Guidelines guidance document
  - Continuation of the establishment of an electronic submission portal for the annual county/city budgets.

- **Phase II: July - September 2021**
  - Development of auditing tools
- **Phase III: October 2021 – September 2022**
  - Shift to an electronic automated PFG submission by the counties/cities
  - Develop training documents
  - Evaluate and analyze findings and trends
  - Identify gaps and vulnerabilities
- **Phase IV: October 2022- Ongoing**
  - Initiate Memorandum of Understanding between State and counties
  - Continuous monitoring and oversight
  - Continuous updates to standards, policies, and guidelines

3.14 Improving Beneficiary Contact and Demographic Information

3.14.1 Background

Medi-Cal has approximately 13 million enrolled beneficiaries; approximately 80 percent are enrolled in the managed care delivery system and 20 percent are enrolled in the fee-for-service delivery system. County social services departments are delegated by DHCS to process Medi-Cal applications and renewals, as well as to generally provide case management services. Counties use Statewide Automated Welfare Systems (SAWS_ to support and maintain Medi-Cal enrollment processes. The SAWS, of which there are currently three, contain contact and demographic information on enrolled individuals. The systems maintain electronic interfaces with the state-level eligibility and enrollment system (California Healthcare Eligibility, Enrollment, and Retention System) and the state-level eligibility database, the Medi-Cal Eligibility Data System. The Medi-Cal Eligibility Data System is the system of record for purposes of Medi-Cal eligibility information, claims payment, and health plan assignment, among other things.

When a beneficiary has a change in circumstances that affects their eligibility, the beneficiary is required to report changes to their county eligibility worker within ten calendar days of the change. Such changes include but are not limited to address and contact information updates, family size (increases or decreases), access to other health insurance, changes in income, and death. County eligibility workers are then responsible

for ensuring the data maintained in the local county eligibility system is accurate and up to date. Under current state law, Medi-Cal managed care plans have the ability to report updated contact information to the county when they have obtained consent from the beneficiary for such reporting.

Accurate contact and demographic information is critical for purposes of ongoing program enrollment and care management for beneficiaries. This information is used by Medi-Cal fee-for-service providers and Medi-Cal managed care plans, as well as other providers of care, for purposes of effective communication and interaction with Medi-Cal beneficiaries, including deploying care management strategies based on individual needs.

Given the substantial volume of individuals in the process of enrolling in or renewing Medi-Cal coverage, it is critical that DHCS, counties and plan and provider partners have accurate contact and demographic information. A more effective and efficient process for keeping this information up to date in California's systems is needed.

3.14.2 Proposal

DHCS intends to convene a workgroup of interested stakeholders to provide feedback and recommendations on ways in which contact and demographic information can be updated by other entities and the means to accomplish this while maintaining compliance with all applicable state and federal privacy laws. The goal of the workgroup will be to determine the best pathway for ensuring that reported updated data is accurate and can be used in eligibility and enrollment systems/databases without creating unintended consequences for other social services program, Medi-Cal beneficiaries, managed care plans, and the provider community.

3.14.3 Rationale

As DHCS seeks to make improvements in its approach to population-based health care and drive innovation in health care delivery, it is critical that our Medi-Cal providers, managed care plans, county partners, and others have access to accurate, up-to-date contact and demographic information for beneficiaries. County eligibility workers play a key role in ensuring contact information is current; however, there are other entities that interact with Medi-Cal beneficiaries on a regular basis who may have access to more current information. As a result, DHCS would like to leverage and explore the possibility of other entities having the opportunity to also update contact and demographic information about Medi-Cal beneficiaries.

3.14.4 Proposed Timeline

DHCS proposes to engage with key partners during 2022-23 to develop thoughtful and realistic recommendations for implementing improvements in how contact and demographic information can be updated by other entities in addition to county eligibility

workers. Such changes may be effectuated through updates to the Medi-Cal application, use of eligibility online portals and/or other means. As part of the workgroup effort, DHCS will also seek input in terms of timing of implementation, taking into consideration current system migrations, consolidations and/or modernization efforts.

4. Conclusion

DHCS developed these CalAIM proposals with a view toward the future and what will be necessary to more effectively and positively impact Medi-Cal beneficiaries' quality of life. These proposals were drawn from more than a year-long effort by DHCS leadership and staff, as well as engagement with critical partners and experts across the State and the nation. These ambitious proposals represent a long-term vision for advancing and improving the Medi-Cal program in fundamental ways that build upon the foundations established in prior waivers and expansion efforts. The success of the thinking behind CalAIM will fundamentally rest on the collaboration and coordination of DHCS, our plan, provider, county, and legislative partners, and the entire stakeholder community. DHCS recognizes that these proposals will likely require significant time and fiscal investment and look forward to working with our partners and through the budget process to most effectively implement the concepts proposed in this initiative. These efforts are not limited to a single year, but represent DHCS' current vision for what Medi-Cal might be able to achieve over the next five to ten years, and beyond.

5. From Medi-Cal 2020 to CalAIM: A Crosswalk

California is embarking on a new and system-wide initiative to transform how beneficiaries' access Medi-Cal services. As the Medi-Cal program has expanded under the Affordable Care Act and through other state-led initiatives, and with over 80% of beneficiaries now being served through managed care plans, it is an opportune time to consider the patient experience from an even more global perspective. Currently, beneficiaries may need to access six or more separate delivery systems (managed care, fee-for-service, specialty mental health, substance use disorder, dental, In Home Supportive Services, etc.) in order to receive the care they need. This combination of system fragmentation and clinical complexity, and the likelihood of decreased beneficiary capacity, makes access to effective care coordination even more critical.

As such, the state is undertaking a more targeted approach to consolidating its Medi-Cal benefit package to achieve better alignment across the system. While Section 1115 waiver authority has historically been the mechanism of choice for states interested in building and expanding managed care delivery systems, the use of the authority has evolved in recent years. The federal government no longer considers the "savings" generated from the shift from fee-for-service to managed care that occurred 15 years ago in Medicaid as relevant in calculating budget neutrality for waivers. CMS, in recent

guidance, has also discontinued approval of traditional financing mechanisms in the Section 1115 context, namely the availability of federal funds for Designated State Health Programs and Safety Net Care Pools. These factors, combined with new federal managed care regulations, have encouraged DHCS to shift its focus away from the Section 1115 waiver authority to instead leverage other available pathways for innovation in the Medi-Cal program.

In the spring of 2020, in response to the COVID-19 public health emergency, DHCS determined that additional time would be needed to prepare Medi-Cal managed care plans, counties, and a wide array of stakeholders for the transition from the Section 1115 waiver to the CalAIM structure. As such, the state prepared a 12-month extension request for the Medi-Cal 2020 Section 1115 demonstration. The request was posted for public comment in June 2020 and submitted to CMS on September 16, 2020. The 12-month extension is meant to serve as a bridge to a 5-year Section 1115 waiver renewal, primarily to continue key programs that require the authority, including the Global Payment Program (GPP) and the Drug Medi-Cal Organized Delivery System (DMC-ODS). In addition, DHCS is designing a comprehensive Section 1915(b) managed care waiver request for CMS that would also be for a 5-year period.

The following table outlines the proposed approach under CalAIM for each of the key Medi-Cal 2020 waiver elements:

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Medi-Cal Managed Care	X	Transition to new 1915(b) waiver.	The general authority for various Medi-Cal managed care will be shifted from 1115 to 1915(b). This would include PACE models needing waiver approval and Whole Child Model.	January 1, 2022
Whole Person Care Pilots	X	Transition to new 1915(b) waiver and managed care plan contract authority.	Medi-Cal managed care plans would provide a new enhanced care management benefit. Additionally, Medi-Cal managed care plans will have the option to provide a menu of approved in lieu of services. The majority of Whole Person Care services will continue to be available as both enhanced care management and in lieu of services via Medi-Cal managed care plans, and ultimately will be expanded to Medi-Cal managed care plans in non-Whole Person Care counties.	January 1, 2022
PRIME		Transition to managed care directed payment under the Quality Incentive Pool (QIP) Program.	The existing PRIME funding structure was transitioned into QIP directed payments effective July 1, 2020. Network Designated Public Hospital (DPH) systems and the District/Municipal Public Hospitals (DMPHs) will have the opportunity to participate in and receive directed QIP payments from their contracted Medi-Cal managed care plans for reporting on a set of quality improvement measures through the QIP program.	Phase I: July 1 – December 31, 2020 Phase II: January 1, 2021
Health Homes Program	X	Transition to new 1915(b) waiver as Enhanced Care Management.	Medi-Cal managed care plans would provide a new enhanced care management benefit similar to the benefits included in the Health Homes Program. Medi-Cal managed care plans will have the option of providing a menu of approved in lieu of services. Services currently provided to populations with complex health needs under the HHP will become available under the managed care delivery system structure.	January 1, 2022

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals				
Medi-Cal 2020 Waiver Component	**Included in Waiver Extension Through 12/31/21**	**Planned for CalAIM**	**Description**	**Timeline**
Coordinated Care Initiative and Cal MediConnect	X	Managed care authority to new 1915(b) waiver; Extension of 1115A demonstration for Cal MediConnect through 2022; eventual Medicare-Duals Special Needs Plans (D-SNPs).	Transition to standardized mandatory enrollment of dual eligibles into Medi-Cal managed care plans. Multipurpose Senior Services Programs will be carved out; long-term care will be carved in statewide. All Medi-Cal managed care plans will be required to offer coverage through D-SNPs for care coordination and integration of benefits.	CCI program with end date of December 31, 2022
Drug Medi-Cal Organized Delivery System (DMC-ODS)	X	Expenditure authority for residential SUD treatment remains in 1115 waiver; Services and delivery system move to new 1915(b) waiver.	The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care for substance use disorder treatment.	Implementation continues January 1, 2022
Global Payment Program	X	1115 waiver renewal.	Continuation of existing program, with discontinuation of Safety Net Care Pool funds, using only Medicaid Disproportionate Share Hospital (DSH) allotment funds.	January 1, 2022.

Crosswalk of Medi-Cal 2020 Waiver Components to CalAIM Proposals

Medi-Cal 2020 Waiver Component	Included in Waiver Extension Through 12/31/21	Planned for CalAIM	Description	Timeline
Dental Transformation Initiative	X	Transition authority to Medi-Cal State Plan.	New dental benefits and provider payments: • Caries Risk Assessment Bundle for ages 0-6; • Silver Diamine Fluoride for ages 0-6, and specified high-risk and institutional populations Pay for Performance incentives for preventive services and establishing continuity of care through dental homes	January 1, 2022
Community-Based Adult Services (CBAS)	X	1115 waiver renewal.	Services for eligible older adults and those with disabilities to restore or maintain their optimal capacity for self-care. The goal is to delay or prevent inappropriate or personally undesirable institutionalization.	January 1, 2022
Eligibility Authorities	X	1115 waiver renewal.	Full Scope Benefit for Pregnancy Related Beneficiaries with FPL 109-138% and Out of State Former Foster Care Youth.	January 1, 2022
Rady CCS Pilot	X	Not included.	The demonstration project tested two healthcare delivery models for children enrolled in the California Children's Services (CCS) Program.	Expires December 31, 2021
Designated State Health Programs (DSHP)	X	Not included.	Financing mechanism under 1115 waiver which has permitted federal funding for certain State health programs not traditionally allowed for federal funding	Expires December 31, 2020
Tribal Uncompensated Care	X	Not included.	The state makes supplemental payments to Indian Health Service (IHS) and tribal 638 facilities to take into account their responsibility to provide uncompensated care. DHCS will work to implement Tribal FQHCs by January 1, 2021, which will account for the remaining services being billed for under Tribal Uncompensated Care.	Expires December 31, 2021

5.1 Transition of PRIME to Quality Incentive Program

5.1.1 Background

The California Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program built on other delivery system transformation efforts focused on strengthening patient-centered primary and specialty outpatient care, improving care coordination, and providing the right care in the most appropriate settings. A total of 17 Designated Public Hospitals and 34 District and Municipal Public Hospitals participated in PRIME. PRIME was designed to accelerate efforts by participating entities to change care delivery, maximize health care value, and strengthen their ability to successfully perform under risk-based alternative payment models. PRIME was intentionally designed to be ambitious in scope and time limited. Using evidence-based quality improvement methods, the initial work required the establishment of performance baselines followed by target-setting, and the implementation and ongoing evaluation of quality improvement interventions.

In 2017, California created a Quality Incentive Program (QIP) – a managed care directed payment program – for the state's Designated Public Hospitals. The state directs Medi-Cal managed care plans to make QIP payments tied to designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The QIP measures do not directly overlap with any of the quality measures being used in PRIME, rather they are designed to be complementary. The QIP promote access to care, value-based purchasing, and to tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The QIP also creates incentives to build data and quality infrastructure and ties funding directly to these goals, allowing the state to pay for quality and build capacity.

5.1.2 Proposal

DHCS is in the process of transitioning the quality improvement work and funding that has been available through PRIME into the QIP and permitting the District and Municipal Public Hospitals to begin participating in the program, which has enabled hospitals to continue quality improvement efforts underway at all 51 PRIME entities after PRIME expired on June 30, 2020. This transition promotes value-based purchasing, ties funding to quality outcomes, and aligns PRIME entities' transition to the QIP with California's transition to the calendar year rating period for Medi-Cal managed care plans.

There are two key phases in the PRIME-to- QIP transition:

- **Phase I:** Alignment with the calendar year health plan rating period, July 1, 2020 through December 31, 2020

- **Phase II:** Merge to QIP, January 1, 2021 through December 2021, and beyond.

Phase I: Alignment with Calendar Year Rating Period

All 51 PRIME entities transitioned into a six-month transitional program on July 1, 2020 to calibrates the new program to end on the same date as Bridge Period 2019-20, an 18-month rate year for Medi-Cal managed care plans that ended on December 31, 2020. For performance on both the original QIP quality metrics (for Designated Public Hospitals) and the PRIME transition metrics (for Designated Public Hospitals and 34 District and Municipal Public Hospitals) during this period, the 51 entities will be paid through Medi-Cal managed care plans, via state-directed Medi-Cal managed care plan payments. CMS approval for this six-month program was obtained on September 14, 2020.

To earn funds for PRIME transition metrics, all 51 PRIME entities will continue to report to DHCS on quality improvement projects and measures from PRIME. The six-month transition will use a twelve-month measurement period to ensure that performance can be fairly compared to benchmarks set by DHCS. Due to the COVID-19 public health emergency, entities will use the March 1, 2019 to February 29, 2020 measurement period and be held to achieving the minimum performance benchmark established by DHCS from PRIME Demonstration Year 15. The Designated Public Hospitals will also continue activities on the original QIP quality metrics during this six-month period, utilizing the same modifications due to the COVID-19 public health emergency outlined for PRIME above.

Phase II: Merge to QIP

Subject to obtaining the necessary federal approvals, January 1, 2021 will be the start of QIP Year 4 and will include the Designated Public Hospitals and 34 District and Municipal Public Hospitals, totaling 51 QIP entities. Similar to Phase I, payments to the 51 QIP entities will be directed payments through the Medi-Cal managed care plans. Program Year 4 will align with Rate Year 2021, corresponding to calendar year 2021.

PRIME Policy Letters and associated PRIME reporting guidance will no longer apply to QIP. DHCS will review all prior PRIME Policy Letters and QIP Policy Letters for relevance and issue updated Policy Letters and reporting guidance to Designated Public Hospitals and District and Municipal Public Hospitals.

DHCS worked with stakeholders to develop a revised metric set for Program Year 4 that prioritizes CMS Adult and Child Core Set measures, HEDIS measures, other nationally vetted and endorsed measures, and measures in wide use across Medicaid quality initiatives. The measures align with well-established benchmarks and State, Medi-Cal managed care plan, and hospital system goals. The Program Year 4 metric set meaningfully reflects the goals and priorities of CalAIM.

5.1.3 Rationale

The QIP Program is intended to promote access to care, value-based payments, and tie funding to quality outcomes, while at the same time further aligning state, Medi-Cal managed care plan, and hospital system goals. The PRIME to QIP transition will engage both Designated Public Hospitals and 34 District and Municipal Public Hospitals to continue quality improvement work for select priority metrics in QIP As such, this proposal will help achieve the following goals of CalAIM:

- Enhance coverage expansion to address health disparities among vulnerable populations;
- Drive delivery transformation across Designated Public Hospitals and District and Municipal Public Hospitals toward value-based care and away from volume-based care, and
- Reduce variation and complexity across hospital systems through alignment of quality measures with those required of health plans.

5.1.4 Proposed Timeline

January 1, 2021: Complete transition from PRIME to QIP for Designated Public Hospitals and District and Municipal Public Hospitals using new CMS Adult and Child Core Set measures, HEDIS measures, and other nationally-vetted and endorsed measures

5.2 Global Payment Program Extension

5.2.1 Background

The Global Payment Program is a five-year pilot program included in California's Medi-Cal 2020 Section 1115 demonstration waiver. The Global Payment Program establishes a statewide pool of funding by combining a portion of California's federal Disproportionate Share Hospital (DSH) allotment with available uncompensated care funding. These funds support public health care system efforts to provide health care for California's uninsured population and promotes the delivery of more cost-effective and higher-value care to the uninsured.

Global budgets are allocated to public health care systems based on available funding and service point thresholds to be achieved. Public health care systems can achieve their hospital specific global budget by meeting a service point threshold that incentivizes movement from high cost, avoidable services to providing higher value and preventive services in the most appropriate setting.

The Global Payment Program's requirements are established in the Special Terms and Conditions for California's Medi-Cal 2020 Section 1115 demonstration and the program

funding is authorized December 31, 2021 under the one year Medi-Cal 2020 extension proposal, submitted to CMS on September 16, 2020.

5.2.2 Proposal

DHCS proposes to extend the Global Payment Program under CalAIM through a renewal of the Medi-Cal Section 1115 waiver demonstration. The Global Payment Program will operate under the following assumptions:

- The start date of Program Year 7 will begin on January 1, 2022, and end on December 31, 2022. The Global Payment Program was originally approved through June 30, 2020. On August 3, 2020, the Centers for Medicare and Medicaid Services (CMS) approved a waiver amendment extending the program and authorizing Program Year 6A for the period of July 1, 2020 through December 31, 2020. The Medi-Cal 2020 one-year extension proposal extended the program through December 31, 2021.
- The Global Payment Program under CalAIM will be funded solely by a portion of the State's Designated Public Hospital Disproportionate Share Hospital allotment allocation and will no longer incorporate uncompensated care funding;
- The percentage of Designated Public Hospital Disproportionate Share Hospital allotment funds to be split amongst University of California hospitals and Global Payment Program public health care systems will remain constant for the entirety of the waiver with 78.104% allocated to the Global Payment Program and 21.896% allocated to University of California hospitals;
- The Global Payment Program will include an evaluation to continue to assess whether the program is achieving its stated goals;
- The Global Payment Program will continue the shifting of point values for specific services to incentivize the provision of care in the most appropriate and cost-effective settings;
- DHCS may recalibrate the initial point thresholds for each hospital. Some public health care systems consistently exceed their thresholds, while others do not. Recalibration of the initial point thresholds will serve to minimize payment adjustments; and
- All other facets of the Global Payment Program in the CalAIM period will operate per the Medi-Cal 2020 waiver Special Terms and Conditions.

5.2.3 Rationale

The Global Payment Program was established to accomplish the following goals:

- To improve health of the remaining uninsured through coordination of care and to move away from the cost-based payment methodology restricted to mostly hospital settings to a more risk-based and/or bundled payment structure;
- To encourage public healthcare systems to provide greater primary and preventive services, as well as alternative modalities such as phone visits, group visits, telemedicine, and other electronic consultations; and
- To emphasize the value of coordinated care and alternative modalities by recognizing the higher value of primary care, ambulatory care, and care management as compared to the higher cost, avoidable emergency room visits and acute care hospital stay.

DHCS collaborated with the RAND Corporation to conduct an evaluation of the Global Payment Program from the onset of the program through March 2019. The evaluation assessed whether and to what extent, changing the payment methodology resulted in a more patient-centered system of care. Results show that there has been an increase in outpatient services, an increase in access to care for the uninsured, an improvement in the coordination of care, advancements in data collection and tracking, and an appropriate allocation of resources to effectively tailor care to more appropriate settings.

These findings provide strong support for the argument that the Global Payment Program is a powerful catalyst in helping the public health care systems deliver more cost-effective and higher-value care to the State's remaining uninsured individuals and will continue to move in this direction over the next five years.

5.2.4 Proposed Timeline

DHCS proposes to extend the Global Payment Program for the next five years according to the schedule in **Attachment G.**

6. Appendices

Appendix A: 2021 and Beyond: CalAIM Implementation Timeline[3]

Date	Implementation Activity
July 1, 2020	**PRIME transitions to Quality Incentive Program**
January 1, 2021	12-month extension of Medi-Cal 2020 demonstration
April 2021	**Submission of Section 1915(b) and 1115 waiver requests** **Pharmacy Carve-Out Effective**
June 2021	**County Oversight[4]:** DHCS will engage with counties by forming a working group that will focus on developing new county performance standards monitoring and reporting mechanism. The reinstatement of County Performance Standards will include incorporation of MEDS alert monitoring statewide **County oversight (CCS, CHDP):** Development of auditing tools. **Foster Care Model of Care Workgroup** completed
October 2021	**County oversight (CCS, CHDP):** Shift to automated Plan and Fiscal Guideline submission process, develop training documents, evaluate and analyze findings and trends, and identify gaps and vulnerabilities.
November-2021	**County Inmate Pre-Release Application Process:** Stakeholder process
December 2021	**County Oversight**: DHCS will publish an updated process for the monitoring and reporting of County Performance Standards, incorporating an outline of the tiered Corrective Action steps which will include disciplinary action ranging from CPAs for counties that do not meet performance expectations, to potential fiscal penalties for unresponsive counties. **Goal approval date of Section 1915(b) and 1115 waiver requests**
2022	

[3] Implementation date TBD: IMD SMI/SED waiver, regional contracting (will vary), improving beneficiary contact and demographic information

[4] Given the Executive Order to halt all county renewal processes and negative actions through the duration of the Public Health Emergency (PHE), the implementation timeline reflected for this initiative will shift if the PHE is extended. The dates noted are based on the PHE ending and normal county business processes resuming January 2021, allowing 12 months from the end of the PHE for counties to process and clean-up the resulting backlog. Dates are subject to change once the end of the PHE is established.

Date	Implementation Activity
January 1, 2022	**Managed Care Authority:** Shifts to 1915(b) authority **Implementation of the following CalAIM proposals:** • Enhanced care management/In lieu of services (existing WPC and/ or HHP target populations) • Incentive payments • Dental benefits and pay for performance (implementation date TBD as funding for Designated State Health Programs (DSHP) is not approved in extension of the Medi-Cal 2020 demonstration) • Managed care benefit standardization continues • Mandatory managed care • Regional Rates Phase I • DMC-ODS renewal and policy improvements • Changes to behavioral health medical necessity • Multipurpose Senior Services Program carved-out of managed care • D-SNP look-alike enrollment transition in CCI counties **County Inmate Pre-Release Application Process:** Publication of guidance and begin Technical Assistance (through December 2022)
March 2022	**County Oversight**: DHCS will begin assessing County Performance Standards, in keeping with the aforementioned updated process.
June 2022	**County Oversight**: DHCS will implement the County Performance Monitoring Dashboard. The dashboard is envisioned to represent county performance in application processing, renewal processing, and MEDS alert processing, and could potentially include other measures to be mutually agreed upon in the future.
July 2022	**Behavioral Health Payment Reform** **Enhanced care management:** • Implementation of additional enhanced care management Target Populations in HHP/WPC Counties. • Managed care plans in non- WPC and/or HHP counties begin implementing enhanced care management target populations
September 2022	**County Oversight**: DHCS will begin publishing the County Performance Monitoring Dashboard on the CHHS Open Data Portal.
October 2022	**County oversight (CCS, CHDP):** Initiate Memorandum of Understanding between State and counties, continuous monitoring and oversight, and continuous updates to standards, policies, and guidelines
December 31, 2022	**Cal MediConnect:** End of program
2023	
January 2023	**Aligned Enrollment:**

Date	Implementation Activity
	• Require statewide mandatory enrollment of dual eligibles in Medi-Cal managed care[5] • All Medi-Cal health plans in CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as an Medi-Cal managed care plan, including dual eligible LTC residents • Require statewide mandatory enrollment for eligible LTC residents for both non-dual and dual beneficiaries **County Inmate Pre-Release Application Process:** Implementation **Shared Risk/Shared Savings** (at the earliest) **Enhanced care management:** Implementation of all enhanced care management target populations, including Individuals Transitioning from Incarceration.
December 2023	**County Oversight**: DHCS will begin taking steps toward fiscal sanctions for counties who do not demonstrate sufficient improvement in meeting performance expectations or are unresponsive.
2024	
January 2024	**Regional Rates, Phase II** (at the earliest)
2025	
January 2025	**Aligned Enrollment:** • All Medi-Cal health plans in non-CCI counties required to operate Dual Eligible Special Needs plans in all service areas they operate as a Medi-Cal managed care plan.
2026	
January 2026	**NCQA:** All Medi-Cal managed care plans required to be NCQA accredited
2027	
January 2027	**Behavioral Health Administrative Integration:** submit for a single, integrated behavioral health managed care plan in each county or region responsible for providing, or arranging for the provision of, specialty mental health and substance use disorder services under the 1915(b) waiver **Long-Term Services and Supports, Long-Term Care, Dual Eligible Special Needs Plans:** Full implementation **Full Integration Plan:** Go Live (no sooner than)

[5] Mandatory Managed Care enrollment: See **Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage.**

Appendix B: Targeted Case Management

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X		
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County				X		
Kings County						X
Lake County						X
Lassen County						X
Los Angeles County	X			X		

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County	X	X	X	X	X	
Merced County						X
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X	X	X	X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County				X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	
San Francisco County						X
San Joaquin County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Luis Obispo County	X	X		X		
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X	X	
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X	X	
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**24**	**16**	**30**	**15**	**30**

Appendix C: County Inmate Pre-Release Application Process sample contracting Models

Contracting Model	Counties Currently Using a Similar Process
County Contracts with County Sheriff's Office	Butte Kern San Bernardino San Diego San Francisco Tuolumne Ventura Yolo
County Contracts with County Jail	Glenn Santa Barbara
County Contracts with Multiple Entities (e.g. Community Based Organizations and County Sheriff's Office)	Contra Costa Imperial Placer Sacramento San Luis Obispo San Mateo Solano Sutter

Appendix D: Institutions for Mental Disease/Serious Mental Illness/Severe Emotional Disturbance Demonstration Goals & Milestones

Below is a summary of demonstration goals as outlined in CMS SMD Letter #18-011:

- Reduced utilization and lengths of stay in emergency departments among Medicaid beneficiaries with serious mental illness or serious emotional disturbance while awaiting mental health treatment in specialized settings;
- Reduced preventable readmissions to acute care hospitals and residential settings;
- Improved availability of crisis stabilization services including services made available through call centers and mobile crisis units, intensive outpatient services, as well as services provided during acute short-term stays in residential crisis stabilization programs, psychiatric hospitals, and residential treatment settings throughout the state;
- Improved access to community-based services to address the chronic mental health care needs of beneficiaries with serious mental illness or serious emotional disturbance including through increased integration of primary and behavioral health care; and
- Improved care coordination, especially continuity of care in the community following episodes of acute care in hospitals and residential treatment facilities.

Below is a summary of demonstration milestones as outlined in CMS SMD Letter #18-011:

- Ensuring quality of care in psychiatric hospitals and residential settings. Involves facility accreditation, unannounced visits, use of a utilization review entity, facilities meeting federal program integrity requirements, and facilities having the capacity to address co-morbid physical health conditions;
- Improving care coordination and transitions to community-based care. Involves implementation of a process to assess housing situations, requirement that facilities have protocols to contact beneficiaries within 72-hours after discharge, strategies to prevent or decrease lengths of stays in emergency departments, and strategies to develop and enhance interoperability and data sharing;
- Increasing access to continuum of care including crisis stabilization services. Involves annual assessments of availability of mental health services across the state, commitment to an approved finance plan, strategies to improve the state's

capacity to track available beds, and implementation of an evidence-based assessment tool; and

- Earlier identification and engagement in treatment including through increased integration. Involves strategies for identifying and engaging individuals in treatment sooner, increased integration of behavioral health care in non-specialty settings and establishing specialized settings and services.

Federal Application Requirements

States wishing to pursue this demonstration opportunity must first submit an application to CMS. CMS will consider a state's commitment to ongoing maintenance of effort on funding outpatient community-based mental health services as demonstrated in their application when determining whether to approve a state's proposed demonstration project to ensure that resources are not disproportionately drawn into increasing access to treatment in inpatient and residential settings at the expense of community-based services. Below is a summary of required elements for the application;

- A comprehensive description of the demonstration, including the state's strategies for addressing the goals and milestones discussed above for this demonstration initiative;
- A comprehensive plan to address the needs of beneficiaries with serious mental illness or serious emotional disturbance, including an assessment of how this demonstration will complement and not supplant state activities called for or supported by other federal authorities and funding streams;
- A description of the proposed health care delivery system, eligibility requirements, benefit coverage and cost sharing (premiums, copayments, and deductibles) required of individuals who will be impacted by the demonstration, to the extent such provisions would vary from the state's current program features and the requirements of the Social Security Act;
- A list of the waivers and expenditure authorities that the state believes to be necessary to authorize the demonstration;
- An estimate of annual aggregate expenditures by population group impacted by the demonstration, including development of baseline cost data for these populations.
- Specifically, CMS requests that states' fiscal analysis demonstrate how the proposed changes will be budget neutral, i.e., will not increase federal Medicaid spending. CMS will work closely with states to determine the feasibility of their budget neutrality models and suggest changes as necessary;

- Enrollment data including historical mental health care coverage and projected coverage over the life of the demonstration, of each category of beneficiary whose health care coverage is impacted by the demonstration;
- Written documentation of the state's compliance with the public notice requirements at 42 CFR 431.408, with a report of the issues raised by the public during the comment period and how the State considered those comments when developing the final demonstration application submitted to CMS;
- The research hypotheses that are related to the demonstration's proposed changes, goals, and objectives, and a general plan for testing the hypotheses including, if feasible, the identification of appropriate evaluation indicators; and
- An implementation plan describing the timelines and activities necessary to achieve the demonstration milestones including a financing plan. The implementation plan can be submitted with the application, or within 90 days of application approval from CMS.

Other Demonstration Requirements

In addition to the required application elements above, states must also develop the following:

- Demonstration monitoring reports including information detailing the state's progress toward meeting the milestones and timeframes outlined in the implementation plan, as well as information and data so that CMS can monitor budget neutrality.
- A Health IT plan (health information technology plan) that describes the state's ability to leverage health IT, advance health information exchange(s), and ensure health IT interoperability in support of the demonstration's goals.
- Monitoring protocols that identify expectations for quarterly and annual monitoring reports including agreed upon performance measures (see SMD #18-011 for a list of potential measures), measure concepts, and qualitative narrative summaries. The monitoring protocol will be developed and finalized after CMS approval.
- Interim and final evaluations that will draw on the data collected for the milestones and performance measures, as well as other data and information needed to support the evaluation that will describe the effectiveness and impact of the demonstration using quantitative and qualitative outcomes and a cost analysis. An evaluation design will be developed by the state, with technical assistance from CMS, to be finalized within 180 days of the demonstration approval.

States that fail to submit an acceptable and timely evaluation design as well as any monitoring, expenditure, or other evaluation reporting are subject to a $5 million deferral per deliverable.

Key Resources

- State Medicaid Director Letter #18-011: https://www.medicaid.gov/federal-policy-guidance/downloads/smd18011.pdf
- Serious Mental Illness/Serious Emotional Disturbance Demonstration Opportunity Technical Assistance Questions & Answers: https://www.medicaid.gov/federal-policy-guidance/downloads/faq051719.pdf

Appendix E: CalAIM Benefit Changes Chart

Benefit Changes Effective April 1, 2021	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Pharmacy	All pharmacy benefits or services billed by a pharmacy on a pharmacy claim, which includes covered outpatient drugs (including Physician Administered Drugs), medical supplies, and enteral nutrition products. This also includes drugs currently "carved-out" of the managed care delivery system, (e.g., blood factor, HIV/AIDS, antipsychotics, and drugs used to treat substance use disorder), which are currently carved-in to some county operated health systems and AIDS Healthcare Foundation. This does not include any pharmacy benefits or services billed on medical and/or institutional claims.
Benefit Changes Effective January 1, 2022	
Benefits Currently Provided by Medi-Cal Managed Care Plans that will be Carved-Out to Fee-for-Service	
Specialty Mental Health Services	Currently full benefit in Partnership Solano (Kaiser members only) and Kaiser Sacramento
Multipurpose Senior Services Program	Currently full benefit in CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside)
Benefits to be Carved-In to Managed Care Statewide	
Major Organ Transplant	Currently full benefit in county operated health systems counties; non-county operated health systems counties currently only cover kidney transplants
Benefit Changes Effective January 1, 2023	
Benefits to be Carved-In to Managed Care Statewide	
Long Term Care	Long Term Care Umbrella • ICF-DD Disabled (excluding beneficiaries in an ICF-DD Waiver center), Disabled Habilitative, and Disabled Nursing • Pediatric Subacute Care Services • Skilled nursing facility • Specialized Rehabilitative Services in skilled nursing facility and ICF • Subacute Care Services Currently full benefit in county operated health systems and CCI counties (Los Angeles, Orange, San Bernardino, San Diego, San Mateo, Santa Clara, and Riverside); in non-county operated health systems/non-CCI counties, Medi-Cal managed care plans are responsible for the month of admission and the month following

Appendix F: Managed Care Enrollment Proposed Aid Code Group Coverage

Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Adult Expansion	7U, L1, M1	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82, 83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A

[6] Members residing in a LTC facility in a non-LTC aid code subject to the LTC benefit carve-in will be transitioned into managed care based on the Non-Dual/Dual Mandatory and Voluntary timeline.
[7] Non-Dual/Dual Definitions: (1) Non-Dual – A Medi-Cal only beneficiary or a Medi-Cal only beneficiary with Medicare Part A **or** Part B only; (2) Dual – Medi-Cal only beneficiary with Medicare Part A **and** Part B or Medicare Part A, B, and D.
[8] Aid code can have a SOC or no SOC

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Managed Care Enrollment Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	
Aged	10[9], 14, 16, 1E, 1H, 1X, 1Y	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, K4, K8, L6	Non-Dual	All Models	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Non-Dual	COHS, CCI	N/A	All Other Models	COHS, CCI	N/A	All Other Models	All Models	N/A	N/A	
Foster Children	03, 04, 06, 07, 40, 42, 43, 45, 46, 49, 2P, 2R, 2S, 2T, 2U,	Non-Dual	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	COHS	Non-COHS	N/A	

[9] Aid codes 10, 20, 60 are Supplemental Security Income (SSI)/State Supplemental Payment (SSP). Medi-Cal beneficiaries in these three aid codes have mandatory and voluntary enrollments based on different managed care models. These beneficiaries are mandatory in COHS, voluntary in San Benito, voluntary in GMC/Regional/Two-Plan for duals, and mandatory in GMC/Regional/Two-Plan for non-duals.

Managed Care Enrollment Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4S, 4T, 4W, 5K, 5L										
Omnibus Budget Reconciliation Act (OBRA) Restricted Scope Only	58	Non-Dual	Napa, Solano, and Yolo counties	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Non-Dual	COHS & CCI	N/A	All Other Models	N/A	N/A	All Models	N/A	N/A	All Models
Non-Disabled Adults (19 & Over)	01, 02[8], 08, 30, 34, 35, 37, 39, 38, 54, 59, 81[8], 82 ,83, 84, 85, 0A, 3D, 3E, 3N, 3P, 3U, 7S, G0, J1, J2, K1, K2, K6, M3	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Non-Disabled Children (Under 19)	30, 32, 33, 34, 35, 37, 38, 39, 47, 54, 59, 72, 82, 83, 2C, 3A, 3C, 3D, 3E, 3F, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4N, 4U, 5C, 5D, 5E, 6P,	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A

Managed Care Enrollment

Aid Code Group Coverage

			Current			2022			2023		
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
	7A, 7J, 7T, 7W, 7X, 8P, 8R, 9H, E6, E7, H1, H2, H3, H4, H5, M5, P5, P7, P9, T1, T2, T3, T4, T5										
Aged	10[2], 14, 16, 1E, 1H, 1X, 1Y	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Breast and Cervical Cancer Treatment Program (BCCTP)	0M, 0N, 0P, 0W	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Disabled	20[2], 23, 24, 26, 27, 36, 60[2], 63, 64, 66, 67, 88, 89, 2E, 2H, 6A, 6C, 6E, 6J, 6G, 6H, 6N, 6R, 6V, 6W, 6X, 6Y, 8G, 9L, L6, K4, K8	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Long Term Care (includes LTC SOC)	13, 23, 53, 63	Dual	COHS, CCI	All Other Models	N/A	COHS, CCI	All Other Models	N/A	All Models	N/A	N/A
Share of Cost	17, 27, 37, 50, 53, 58, 67, 71, 73, 81[8], 83, 85, 87, 89, 02[8], 1Y, 4V, 5F, 5R, 6R, 6W, 6Y, 7M, 7P, 7R, 7V, 8V, C2, C4, C6, C8, D1, D3, D5, D7, D9	Dual	COHS, CCI	N/A	Non-COHS & Non-CCI	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment												
Aid Code Group Coverage												
			Current			2022			2023			
Aid Code Group	**Aid Codes[6]**	**Non-Dual/ Dual[7]**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
Presumptive Eligibility (Hospital and CHDP PE)	2A, 4E, 8L, 8W, 8X, H0, H6, H7, H8, H9, P1, P2, P3	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Trafficking and Crime Victims Assistance Program (TCVAP)	2V, 4V, 5V, 7V, R1	Both	N/A	N/A	All Models	All Models	N/A	TCVAP SOC	All Models	N/A	TCVAP SOC
Accelerated Enrollment (AE)	8E	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
Child Health and Disability Prevention (CHDP) Infant Deeming	8U, 8V	Both	N/A	N/A	All Models	All Models	N/A	N/A	All Models	N/A	N/A
State Medical Parole/County Compassionate Release/Incarcerated Individuals	F1, F2, F3, F4, G0, G1, G2, G3, G4, G5, G6, G7, G8, G9, J1, J2, J3, J4, J5, J6, J7, J8, K2, K3,K4, K5, K6, K7, K8, K9, N0, N5, N6, N7, N8, N9	N/A	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models
Limited/Restricted Scope Eligible	48, 50, 53, 55, 58, 69, 71, 73, 74, 76, 77, 80, 0L, 0R, 0T, 0U, 0V, 0X, 0Y, 1U, 3T, 3V, 5J, 5R, 5T, 5W, 6U, 7C, 7F, 7G,	Both	N/A	N/A	All Models	N/A	N/A	All Models	N/A	N/A	All Models

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Managed Care Enrollment											
Aid Code Group Coverage											
			Current			2022			2023		
Aid Code Group	Aid Codes[6]	Non-Dual/ Dual[7]	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment	Mandatory	Voluntary	Excluded from Enrollment
	7H, 7K, 7M, 7N, 7P, 7R, 8N, 8T, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D2, D3, D4, D5, D6, D7, D8, D9, E1, L7, M0, M2, M4, M6, M8, P0, P4, P6, P8, T0, T6, T7, T8, T9, F1, F2, F3, F4, G1, G2, G3, G4, G5, G6, G7, G8, G9, J3, J4, J6, J8, K3, K5, K7, K9, N0, N5, N6, N7, N8, N9										

Pregnancy Related Aid Codes							
	Citizen/Lawfully Present				**Non-Citizen**		
	Aid Codes	**Current**	**Proposed (2021)**		**Aid Codes**	**Current**	**Proposed (2021)**
Title XXI (SCHIP) 213-322%	86, 87, 0E	Full Scope/MC	Full Scope/MC	Title XXI (SCHIP) 213-322%	0E	Full Scope/MC	Full Scope/MC
Title XIX (PRS/ES) 138-213%	44, M9	Limited Scope/FFS	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 138-213%	48, M0	Limited Scope/FFS	Limited Scope/FFS
Title XIX (PRS/ES) 0-138%	M7	Full Scope/MC	Full Scope/MC	Title XXI (PRS – SCHIP) Title XIX (ES) 0-138%	D8, D9, M8	Limited Scope/FFS	Limited Scope/FFS

Population Exclusions									
Populations	**Current**			**2022**			**2023**		
	Mandatory	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**	**Mandatory**	**Voluntary**	**Excluded from Enrollment**
American Indian[10]	COHS	Non-COHS	N/A	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries with Other Healthcare Coverage (OHC)	COHS	N/A	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Rural Zip Codes[12]	COHS	Non-COHS	Non-COHS	All Models[11]	N/A	N/A	All Models[11]	N/A	N/A
Beneficiaries in Home and Community Based Services Waivers	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	COHS & CCI MLTSS = All Non-COHS & Non-CCI = Non-Duals	Non-COHS & Non-CCI = Duals	Cal MediConnect	All Models[11]	N/A	N/A

[10] American Indian Beneficiaries will be enrolled into a managed care plan, but they will have the option to opt out of enrollment if they choose to remain in FFS
[11] Would align with Mandatory/Voluntary/Excluded MC Enrollment by aid code, no special exclusions from enrollment solely based on zip code, OHC, American Indian or 1915c Waiver Enrollment
[12] The following zip codes are currently excluded from enrollment or are voluntary for enrollment: 93558, 90704, 92225, 92226, 92239, 92242, 92267, 92280, 92323, 92332, 92363, 92364, 92366, 93562, 9359293555, 93556, 93560, 92252, 92256, 92268, 92277, 92278, 92284, 92285, 92286, 92304,92305, 92309, 92310, 92311, 92312, 92314, 92315, 92317, 92321, 92322, 92325, 92327, 92333, 92338, 92339, 92341, 92342, 92347, 92352, 92356, 92358, 92365, 92368, 92372, 92378, 92382, 92385, 92386, 92391, 92397, 92398

Appendix G: Global Payment Program Extension Timeline

Program Year	Calendar Year	Federal Fiscal Year	Service Period Dates
6[13]	2021	2021	January 1, 2021-December 31, 2021
7	2022	2022	January 1, 2022 – December 31, 2022
8	2023	2023	January 1, 2023 – December 31, 2023
9	2024	2024	January 1, 2024 – December 31, 2024
10	2025	2025	January 1, 2025 – December 31, 2025
11	2026	2026	January 1, 2026 – December 31, 2026

[13] *PY 6 is part of Medi-Cal 2020 demonstration extension through 12/31/21*

Appendix H: Dental in Proposition 56 vs. CalAIM

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D0120	Periodic oral evaluation – established patient	No	Yes
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No	Yes
D0150	Comprehensive oral evaluation – new or established patient	No	Yes
D0601	Caries risk assessment and documentation, with a finding of low risk (children ages 0-6)	No	Yes
D0602	Caries risk assessment and documentation, with a finding of moderate risk (children ages 0-6)	No	Yes
D0603	Caries risk assessment and documentation, with a finding of high-risk (children ages 0-6)	No	Yes
D1110	Prophylaxis – adult	Yes	No
D1120	Prophylaxis - child	No	Yes
D1206	Topical application of fluoride varnish (child)	No	Yes
	Topical application of fluoride varnish (adult)	Yes	No
D1208	Topical application of fluoride – excluding varnish (child)	No	Yes
	Topical application of fluoride – excluding varnish (adult)	Yes	No
D1310	Nutritional counseling for the control of dental disease (child)	No	Yes

Dental Procedure Code	Description	Proposition 56 Supplemental Payment	CalAIM Performance Payment
D1320	Tobacco counseling for the control and prevention of oral disease (adult)	No	Yes
D1351	Sealant – per tooth (child)	No	Yes
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth (child)	No	Yes
D1354	Interim caries arresting medicament application – per tooth (children ages 0-6 and restricted adult populations)	No	Yes
D1510	Space maintainer – fixed, unilateral – per quadrant (child)	No	Yes
D1516	Space maintainer – fixed, bilateral, maxillary (child)	No	Yes
D1517	Space maintainer – fixed, bilateral, mandibular (child)	No	Yes
D1526	Space maintainer – removable, bilateral, maxillary (child)	No	Yes
D1527	Space maintainer – removable, bilateral, mandibular (child)	No	Yes
D1551	Re-cement or re-bond space maintainer – bilateral space maintainer, maxillary (child)	No	Yes
D1552	Re-cement or re-bond space maintainer – bilateral space maintainer, mandibular (child)	No	Yes
D1553	Re-cement or re-bond space maintainer – unilateral space maintainer – per quadrant (child)	No	Yes
D1556	Removal of fixed unilateral space maintainer – per quadrant (child)	No	Yes
D1557	Removal of fixed bilateral space maintainer – maxillary (child)	No	Yes
D1558	Removal of fixed bilateral space maintainer – mandibular (child)	No	Yes
D1575	Distal shoe space maintainer – fixed unilateral – per quadrant (child)	No	Yes
D1999	Unspecified preventive procedure, by report (adult)	No	Yes

Appendix I: Enhanced Care Management Target Population Descriptions

Enhanced care management is designed for populations who have the highest levels of complex health care needs as well as social factors influencing their health. To be eligible for enhanced care management, members must meet criteria below in addition to any criteria specific to the respective enhanced care management population:

1. Have complex physical or behavioral health condition with inability to successfully self-manage AND
2. Limited activity or participation in social functioning as defined by at least one of the following:
    a. Establishing and managing relationships;
    b. Major life areas, including education, employment, finances, engaging in the community

Candidates for enhanced care management have an opportunity for improved health outcomes if they receive high-touch, in-person care management and are connected to a multidisciplinary team that manages physical health, behavioral health (substance use and/or mental health), oral health, developmental disabilities, and health-related non-clinical needs as well as any needed long-term services and supports.

Enhanced care management will be implemented in phases:

- January 1, 2022: All Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will begin implementation of the enhanced care management benefit, for those target populations currently receiving Health Homes Program and/or Whole Person Care services.
- July 1, 2022:
    - Medi-Cal managed care plans in counties with Whole Person Care pilots and/or Health Homes Programs will implement additional mandatory enhanced care management target populations.
    - All Medi-Cal managed care plans in counties without Whole Person Care pilots and/or Health Homes Programs must begin implementation of select enhanced care management target populations.
- January 1, 2023: All Medi-Cal managed care plans in all counties must implement enhanced care management for all target populations.

Characteristics of ECM target populations are set forth below and detailed further in this document. Risk stratification is the responsibility of the Medi-Cal managed care plans,

which will determine member needs and apply criteria to determine eligibility and facilitate ECM services. Medi-Cal managed care plans may propose additional populations to receive ECM or propose expansions of criteria within populations. ECM target populations are subject to further refinement by DHCS.

Medi-Cal managed care plans may propose additional populations to receive enhanced care management, for example to allow the transition for members receiving services under a Whole Person Care pilot. At a minimum, Medi-Cal managed care plans must provide enhanced care management to the below list of mandatory target populations:[14]

- Children and youth with complex physical, behavioral, and/or developmental health needs (i.e. California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).
- Individuals experiencing homelessness, chronic homelessness or who are at risk of becoming homeless.
- High utilizers with frequent hospital admissions, short-term skilled nursing facility stays, or emergency room visits.
- Individuals at risk for institutionalization, eligible for long-term care.
- Nursing facility residents who want to transition to the community.
- Individuals at risk for institutionalization with Serious Mental Illness (SMI), children and youth with Serious Emotional Disturbance (SED) or Substance Use Disorder (SUD).
- Individuals transitioning from incarceration who have significant complex physical or behavioral health needs requiring immediate transition of services to the community.

These target population descriptions are intended as guidance for Medi-Cal managed care plans. Managed care plans will determine criteria for population identification and stratification in accordance with this guidance.

Settings

For all populations, the role of enhanced care management is to coordinate all primary, acute, behavioral, developmental, oral, and long-term services and supports for the

[14] Individuals transitioning from incarceration must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

member, including participating in the care planning process, regardless of setting. This benefit is intended to provide primarily face-to-face services whenever possible.

Services should be offered where the members live, seek care or prefer to access services, essentially meeting the member (and, for children and youth, their family, caretaker or circle of support) where they are within the community. This may include different settings based on the target population. For example, for individuals experiencing homelessness, enhanced care management care managers may conduct street outreach or coordinate with shelters, hotels or motels including those participating in Project Homekey, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals in these settings. For individuals with SMI and/or SUDs, initial contact may be in settings such as psychiatric inpatient units, Institutions for Mental Disease (IMDs) or residential settings. Children and youth may receive services in a variety of community settings, including homes and schools, where appropriate. These are examples of how enhanced care management settings will reflect individualized needs of the target populations.

Risk Stratification

Enhanced care management is the highest tier of case management and is intended for members at the highest risk level who need long-term coordination for multiple chronic conditions, social determinants of health issues, and utilization of multiple service types and delivery systems. As part of their plan submitted to DHCS, Medi-Cal managed care plans will detail the algorithms, processes, and partnerships they will use to identify those individuals who have the highest levels of complex health care needs and social factors influencing their health, and who present the best opportunity for improved health outcomes through enhanced care management services.

Algorithms and data sources may vary by population. For example, some individuals may be identified using claims data and/or other health assessment information to identify multiple complex conditions or a history of utilization of high-cost services.

However, for a variety of reasons, claims data may be insufficient to identify other good candidates for enhanced care management. For some members, access to care issues and multiple social factors may limit the utility of claims data in identifying health risks. Therefore, managed care plans must also use data sources that capture social determinants of health as well as referrals. For individuals experiencing homelessness, data systems such as the Homeless Management Information System (HMIS) may be used. For individuals transitioning from incarceration, data sharing agreements with city and county jail systems to identify those at highest risk may be considered

For many populations, referrals and partnerships will be a critical method to identify enhanced care management candidates. Entities such as health care providers, community-based organizations, social services agencies, tribal partners, and local governments are important partners in identifying individuals who are at high risk of significant health care utilization and who would benefit from enhanced care management. Medi-Cal managed care plans are encouraged to partner with these entities to ensure enhanced care management benefits are highly coordinated with other service types. Medi-Cal managed care plans should also plan to establish clear protocols to receive and consider enhanced care management referrals from external entities.

Core Components of Enhanced Care Management Services

The types of supports and services provided through enhanced care management may vary based on the needs of the target populations. In the individual target population descriptions, this document describes examples of interventions that enhanced care management may support for each unique target population. However, core components of enhanced care management that are universal for all target populations include:

- Comprehensive Assessment and Care Management Plan:
    - Engage with Members authorized to receive the enhanced care management Benefit primarily through in person contact;
        - *When in-person communication is unavailable or does not meet the needs of the Member, use alternative methods to provide culturally appropriate and accessible communication.*
    - Develop a comprehensive, individualized, person-centered care plan by working with the Member, and as appropriate their chosen family/support persons, to assess strengths, risks, needs, goals, and preferences
    - Incorporate into the Member's care plan needs in the areas including, but not limited to physical and developmental health, mental health, SUD, community-based Long-Term Services and Supports (LTSS), oral health, palliative care, trauma-informed care, necessary community-based and social services, and housing;
    - Ensure the care plan is reassessed at a frequency appropriate for the Member's individual progress or changes in need.
- Enhanced Coordination of Care:
    - Organize patient care activities as laid out in the care plan, share information with the Member's key care team, and implement the Member's care plan;

- Be continuous and integrated among all service providers and refer to primary care/physical and developmental health, mental health, SUD treatment, community-based LTSS, oral health, palliative care, trauma-informed care, necessary community-based and social services, and, housing, as needed;
- Provide support for Member treatment adherence including coordination for medication review/reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, identifying barriers to adherence, ensuring continuous enrollment in Medi-Cal, and maintaining social services benefits, and accompaniment to key appointments;
- Communicate Members' needs and preferences timely to all members of the Members' care team in a manner that ensures safe, appropriate, and effective person-centered care;
- Be in regular contact with the Member, consistent with the care plan;

- Health Promotion:
  - Work with Members to identify and build on resiliencies and potential family or community supports;
  - Provide services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health;
  - Support the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.
- Comprehensive Transitional Care
  - Perform engagement activities that seek to reduce avoidable Member admissions and readmissions;
  - For Members that are experiencing or are likely to experience a care transition:
    - Develop and regularly update a transition plan for the Member, and incorporate it into the Member's care plan;
    - Evaluate a Member's medical care needs and coordination of any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges;

- Track each Member's admission or discharge to/from an emergency department, hospital inpatient facility, skilled nursing facility, residential/treatment facility, incarceration facility, or other treatment center and communicate with the appropriate care team members;
- Coordinate medication review/reconciliation; and
- Provide adherence support and referral to appropriate services.

- Member and Family Supports:
  - Document a Member's chosen caregiver or family/support person;
  - Include activities that ensure that the Member and chosen family/support persons, including as guardians and caregivers, are knowledgeable about the Member's condition(s) and care plan with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management;
  - Serve as the primary point of contact for the Member and their chosen family/support persons;
  - Identify supports needed for the Member and chosen family/support persons to manage the Member's condition and direct them to access needed support services, including peer supports when applicable and available; and,
  - Provide for appropriate education of the Member, family members, guardians, and caregivers on care instructions for the Member.
- Coordination of and Referral to Community and Social Support Services:
  - Determine appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services that are offered by managed care plan as an ILOS;
  - Coordinate and referring Members to available community resources and following up with Members to ensure services were rendered (i.e. "Closed loop referrals").

Target Populations

A description of each population is outlined below. Beneficiaries must be enrolled in Medi-Cal managed care to receive enhanced care management. In general, for all target populations, individuals who, after multiple outreach attempts, using different modalities, opt not to participate in enhanced care management services or whose assessment

(completed or confirmed by the managed care plan) indicates they would not benefit from the services, would not be good candidates for enhanced care management. The number of outreach attempts and approaches will vary based on the populations and individualized needs.

Enhanced care management is designed to provide support to individuals who require high levels of intensive interventions. Individuals who are receiving or who would benefit from other existing types of interventions (e.g., end of life care, standard case management, disease management or other care coordination efforts) would not be appropriate candidates for enhanced care management unless those interventions are not successful. Medi-Cal managed care plans and/or their subcontractors or contracted providers will evaluate individuals for enhanced care management and not all individuals will be good candidates. For example, individuals with the following circumstances may not be good candidates for enhanced care management:

- Individuals who have a well-treated chronic disease and are compliant with their care plan and have unavoidable or expected admissions due to the condition.
- Individuals who refuse to engage in any telephonic or face to face case management after multiple outreach attempts using different modalities.
- Individuals receiving services that the managed care plan determines to be duplicative of enhanced care management, such as 1915(c) Home and Community Based Services (HCBS) Waiver programs.

All Medi-Cal beneficiaries currently receiving care management through the Health Homes Program and Whole Person Care shall be transitioned to enhanced care management through one of the target populations listed and will be reassessed.

The populations eligible for enhanced care management are those with the highest needs who use multiple delivery systems and services, who need ongoing coordination across medical, behavioral and social needs, and who are part of the mandatory target populations described below. Note that some enhanced care management candidates will meet criteria for multiple target populations. Medi-Cal managed care plans will assign these individuals authorized to receive enhanced care management services to an enhanced care management provider that has appropriate competencies and experience for the needs of the beneficiary. For example, individuals with SMI or SUDs may also be homeless or high utilizers. These members may be assigned to an enhanced care management provider that has the necessary skills and experience to work with individuals with SMI and SUDs.

Children and Youth

Target Population:

Children and youth (up to age 21, or foster youth to age 26) with complex physical, behavioral, and/or developmental health needs, with significant functional limitations and social factors influencing their health outcomes (e.g., California Children Services, foster care, youth with Clinical High-Risk syndrome or first episode of psychosis).

For example:

- Children/Youth with complex health needs who are medically fragile or have multiple chronic conditions. This may include children with a history of trauma and children who are engaged or have history with the child welfare system. These children often access care across multiple service delivery systems and require significant coordination to ensure their needs are being met.

- Children/Youth with significant functional limitations and multiple social factors influencing their health outcomes.

Enhanced Care Management Services:

Enhanced care management can be used to assess gaps in both health care and social support needs and develop a care plan that addresses the whole health needs of the child. While Medi-Cal managed care plans may use claims data to identify good candidates, referrals will be an important mechanism to identify children and youth who would benefit from enhanced care management. Health care providers, the child welfare system, schools, community-based organizations, California Children's Services (CCS), county behavioral health, and social services agencies are examples of other important potential referral partners for children/youth. Medi-Cal managed care plans should establish a process for providers to refer for enhanced care management based on a needs assessment, behavioral health screens, other EPSDT screening, and/or ACE score which includes consideration of the community supports available for the children and their families and caretakers, as well as social factors impacting their health.

Services should be offered where the members live, seek care or where the family, caretaker, or circle of support prefers to access services, essentially meeting the member and family/caretaker/support where they are within the community. Activities may include coordination in school-based settings if permitted by the schools. Services should be offered by culturally and linguistically aligned trauma-informed providers.

For this population, enhanced care management services include (but are not limited to):

- Helping families, caretakers, and circles of support access resources such as information, coordination, and education about the child's conditions.
- Identifying coordinating, and providing (when appropriate) services that will help families, caretakers, and circles of support with the health needs of their children, which may include referrals for services those individuals need to enable them to support their children's health (e.g., referral to behavioral health, including SUD services, for a parent, or housing-related services for households experiencing homelessness, either of which could be critical to ensure the parent can support the health needs of the child).
- Referral to housing related services for youth experiencing homelessness.
- Coordination of services across various health, behavioral health, developmental disability, housing and social services providers, including facilitating cross-provider data- and information-sharing and member advocacy to ensure the child's whole person needs are met and needed services are accessible.
- Assistance with accessing respite care as needed.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health.
- Coordination of other services as required by EPSDT.
- Referral to community and social services to address food insecurity and other social factors that may impact the child's health

Homeless

Target Population:

Individuals experiencing homelessness or chronic homelessness, or who are at risk of experiencing homelessness (as defined below), with complex health and/or behavioral health needs, for whom coordination of services would likely result in improved health outcomes and decreased utilization of high-cost services.

For example:

- Individuals with complex health care needs as a result of medical, psychiatric or SUD-related conditions, who may also experience access to care issues (resulting in unmet needs or barriers to care) and multiple social factors influencing their health outcomes.
- Individuals with repeated incidents of avoidable justice involvement, emergency department use, psychiatric emergency services or hospitalizations.

Homeless: Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution). For the purpose of enhanced care management, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

A. In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.

B. By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:

1. A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

    i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

    ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:

(1) An individual or family who:

(i) Has an annual income below 30 percent of median family income for the area, as determined by HUD;

(ii) Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and

(iii) Meets one of the following conditions:

(A) Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

(B) Is living in the home of another because of economic hardship;

(C) Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

(D) Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

(E) Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

(F) Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

(G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

(2) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

(3) A child or youth who does not qualify as “homeless” under this section, but qualifies as “homeless” under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who meet the State’s No Place Like Home definition for a person with SMI and/or SED “at risk of chronic homelessness,” which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with

significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Enhanced Care Management Services:

Individuals experiencing or at risk of homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. Individuals often have high medical needs that are difficult to manage due to the social factors that influence the individual's health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, homeless services providers, recuperative care providers, community partners (e.g., homeless coordinated entry systems) and other service providers to connect with target individuals.[15] As individuals are connected to resources, the enhanced care management care coordinator will meet the member in the community or at provider locations.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. This includes (but is not limited to):

- Utilizing housing-related in-lieu-of services (ILOS) to identify housing and prepare individuals to for securing and/or maintaining stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to ensure progress towards regaining health and function continues.
- Coordinating and collaborating with various health and social services providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to

[15] These same entities will be important referral partners to identify potential enhanced care management candidates

public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.

- Addressing barriers to housing stability by connecting member to housing, health, and social support resources.
- Utilize best practices for Member who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care

High Utilizers

Target Population:

High utilizers are Members with multiple hospital admissions, OR multiple short-term skilled nursing facility stays, OR multiple emergency room visits that could be avoided with appropriate outpatient care or improved treatment adherence.

For example:

- Individuals that have impactable conditions or opportunities for interventions that have the potential to decrease inappropriate utilization or can be performed at an alternative location.
- Individuals with repeated incidents of avoidable emergency use, hospital admissions, or nursing facility placement. Individuals with multiple chronic or poorly managed conditions requiring intensive coordination, beyond telephonic intervention.
- Significant functional limitations and/or adverse social determinant of health that impede the ability of the individual to navigate their healthcare and other services.

Enhanced Care Management Services:

Enhanced care management will provide multiple opportunities to engage individuals by stratifying risk and need and developing care plans and strategic interventions to mitigate risk and help clients achieve improved health and well-being. Medi-Cal managed care plans will identify the algorithms they will use to identify individuals who are high utilizers of medical services. DHCS expects Medi-Cal managed care plans will rely on available healthcare research related to appropriate identification of high utilizers and will leverage the managed care plan utilization data to identify members that meet the respective criteria established by the managed care plans.

For this population enhanced care management may include, but is not limited to:

- Frequent follow up visits, culturally and linguistically appropriate education and care coordination activities to ensure the member's needs are being met where they are.
- Connection to culturally and linguistically appropriate community-based organizations, programs and resources that will meet the member's needs.
- Improving member engagement to improve adherence to the member's treatment plan, including through more culturally and linguistically aligned approaches toward member and provider education and tools on how to increase adherence.

- Medication review, reconciliation, assistance obtaining medications, and culturally and linguistically appropriate reinforcement with medication adherence.

Risk for Institutionalization – Long Term Care

Target Population:

Individuals at risk for institutionalization, eligible for long-term care services. Medi-Cal beneficiaries who, in the absence of services and supports would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF) would qualify.

Individuals must meet NF level of care criteria AND be able continue to live safely in the community with wrap around supports. \

Examples include, but are not limited to:

- Seniors and persons with disabilities who reside in the community but are at risk of being institutionalized.
- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive, or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Would not include:

- Individuals with complex needs but who are not at risk of institutionalization.

Enhanced Care Management Services:

Services include preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. For this population enhanced care management may include, but is not limited to:

- Assessment to determine natural supports available, risk factors, social determinants of health, and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connection to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications), and personal care.
- Frequent follow up visits (including regular home visits), culturally and linguistically appropriate education and care coordination activities to ensure the member and family/caregiver needs are being met where they are.
- Connection to appropriate culturally and linguistically aligned community-based organizations, programs and resources that will meet the member's needs.
- Placement of wrap-around services to maintain the member in their current, community setting.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence, and accompanying members to appointments as needed.

Nursing Facility Transition to Community

Target Population:

Individuals who are currently residing in a Nursing Facility (NF) but desire to return to living in the community. Transition from the NF to community is strictly voluntary. Individuals have the option to transition to the community when that can be done in a cost-effective manner. Individuals must be able to transition safely to the community.

Individuals must have an identified support network system and housing available to them. The support network system may consist of care providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parent, or any other individual who is part of

the individual's circle of support. The individual's circle of support may consist of family members, legal representative/legally responsible adult, and any other person named by the individual.

Would not include:

- Individuals not interested in moving out of the institution.
- Individuals who are not medically appropriate to live in the community (high acuity).
- Individuals whose total projected costs outside the institution are greater than the cost of institutionalization.
- Individuals who do not have the supports to reside safely in the community.
- Individuals who would be at a high risk of re-institutionalization or experiencing homelessness.

Enhanced Care Management Services:

The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

Services include facilitating nursing facility transition back into a homelike and community setting with the necessary wrap-around services, community supports, and natural supports when available.

Enhanced Care Manager care manager visits will occur face to face at the facility throughout the transition process. An in-person home visit will occur prior to the

individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

SMI, SED and SUD Individuals at Risk for Institutionalization

Target Population:

Individuals who are at risk for institutionalization who have co-occurring chronic health conditions and:

- Serious Mental Illness (SMI, adults);
- Serious Emotional Disturbance (SED, children, and youth); or
- Substance Use Disorder (SUD).

Potential candidates include:

- Individuals who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions with co-occurring chronic health conditions, who may also experience access to care issues and have multiple social factors influencing their health outcomes and as a result of these factors are at risk for institutionalization.
- Individuals with repeated incidents of emergency department use, psychiatric emergency services, psychiatric inpatient hospitalizations, including stays at psychiatric health facilities, or short-term skilled nursing facility stays who could be served in community-based settings with supports.

Enhanced Care Manager Services:

For individuals with SMI or SUD, or children and youth with SED, enhanced care management will coordinate across the delivery systems through which members access care. For these individuals, Medi-Cal managed care plans may pursue contracts with county behavioral health systems to perform enhanced care management activities, but this must include coordination of all available services including medical care, behavioral health and long-term services and supports. When managed care plans do not contract with county behavioral health, enhanced care management service providers for this population should have experience and competency in working with individuals with SMI and SUDs as well as a plan to adequately coordinate enhanced care management and behavioral health services and supports across the managed care plan and county behavioral health. Initial engagement may be in treatment settings such as psychiatric inpatient units, IMDs or residential settings.

For children and youth with SED, activities may include coordination in school-based settings if permitted by the schools.

Enhanced care management can be used to link individuals with a variety of services to meet their complex needs. Medi-Cal managed care plans should closely coordinate these

enhanced care management services and supports with county behavioral health to avoid duplication and ensure adequate communication and care coordination. This includes (but is not limited to):

- Provide post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization including identifying appropriate culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Regular culturally and linguistically appropriate contact with members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.

- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.

- Supporting the members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.

- Connecting families, caretakers, and circles of support to resources regarding the member's conditions to assist them with providing support for the member's health/behavioral health.

- Coordinating and collaborating with various health, behavioral health, developmental disability, and social services providers including sharing data (as appropriate).

- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed

Individuals Transitioning from Incarceration[16]

Target Population:

Individuals transitioning from incarceration, including justice-involved juveniles who have significant complex physical or behavioral health needs requiring immediate transition of services to the community. A Medi-Cal managed care plan may stratify eligibility based on populations that have multiple incarcerations, other institutionalizations and/or high utilization. Individuals must have been released from incarceration with the last 12 months.

In addition, this population includes individuals who are involved in pre- or post-booking diversion behavioral health and criminogenic treatment programs and therefore are at risk for incarceration and who could, through care coordination and service placement, have a treatment plan designed to avoid incarceration through the use of community-based care and services.

Enhanced Care Management Services:

Some individuals transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. Individuals often also experience significant social factors that impact their ability to successfully manage their health/behavioral health conditions, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and as a result often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this target population, enhanced care management requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system to both to identify/refer members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and managed care plans on an as needed basis. Medi-Cal managed care plans and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities. Therefore, the enhanced care management care managers will need to coordinate and

[16] This target population must be included no later than 1/1/2023, except where such program already exists today through an existing WPC program, in which case this target group is mandatory as of 1/1/2022.

collaborate closely with county behavioral health departments, and potentially also with Medi-Cal managed care plans, for those individuals.

The initial enhanced care management engagement locations will depend on the collaborations that Medi-Cal managed care plans are able to build with local justice partners. At first, enhanced care management staff will begin work with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[17] Post-transition, enhanced care management care managers will engage individuals in the most easily accessible setting for the member. In addition to community-based engagement such as a member's home or regular provider office, this may also include parole or probation offices if the managed care plan builds partnerships that allow for engagement in those offices.

Enhanced care management can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. This includes (but is not limited to):

- Coordination of an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Direct connections with community providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Regular contact with members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly addressing those gaps to prevent reincarceration and ensure progress towards regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.

[17] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing enhanced care management for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. enhanced care management dollars will not be able to be used to provide services directly to justice involved members prior to release

- Coordinating and collaborating with various health, behavioral health, and social services providers as well as parole/probation including sharing data (as appropriate) to facilitate better-coordinated whole person care.
- Supporting member treatment adherence including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence, and accompanying members to appointments as needed.
- Helping members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers, and circles of support regarding the member's health care needs and available supports.
- Navigating members to other reentry support providers to address unmet needs.
- Facilitating benefits reinstatement.[18]

[18] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023 The enhanced care management care manager would also help facilitate accessing other benefits as needed by the member.

Enhanced Care Management Implementation Dates by County

Counties with Whole Person Care and/or Health Homes[19] (Begin implementation on 1/1/22)		Counties without Whole Person Care or Health Homes (Begin implementation on 7/1/22*)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Luis Obispo
Shasta	WPC	Santa Barbara
Sonoma	WPC	Sierra
Tulare	HHP	Siskiyou
Ventura	WPC	Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne
		Yolo
		Yuba

[19] List is subject to changed based on WPC pilots decisions to continue operating through 2021.

Appendix J: In Lieu of Services Options

Following is the proposed menu of in lieu of services that would be covered under the CalAIM initiative. ILOS are optional for both the plan to offer and the beneficiary to accept. Individuals do not have to be enrolled in Enhanced Care Management to be eligible for in lieu of services. ECM target populations/ILOS Service definitions are subject to further refinement by DHCS.

Each set of services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist beneficiaries with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the participant's preferences and barriers related to successful tenancy. The assessment may include collecting information on the participant's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the participant's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as Section 8, state and local assistance programs etc.) and matching available rental subsidy resources to members.
7. If included in the housing support plan, identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses. [20]
8. Assisting with requests for reasonable accommodation, if necessary.
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the client with landlords.

[20] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[21]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, environmental modifications to install necessary accommodations for accessibility.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy such as County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; local legal service programs, community-based organizations housing providers, local housing agencies and housing development agencies. For clients who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership clients) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted ILOS providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

[21] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            a. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            b. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months

or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

terminated within 21 days after the date of application for assistance;
- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

  - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
  - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services are authorized and identified in the managed care plan contracts.

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan.

Individuals may not be receiving duplicative support from other State, local tax or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;

- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program (See Credentialing/Recredentialing and Screening/Enrollment APL 19-004) if an enrollment pathway exists, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, Medi-Cal managed care plans must credential the providers as required by DHCS.

Clients who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.[22]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient Hospital services, emergency department services, emergency transport services, and skilled nursing facility services.

[22] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with

disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as “a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years.” The definition also includes “an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            c. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
            d. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions

included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions and Limitations

In lieu of services are alternative services covered under the State plan but are delivered by a different provider or in a different setting than is described in the State plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the client owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections.
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy.

Services do not include the provision of room and board or payment of rental costs. Please see housing deposits ILOS.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services ILOS in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:

- In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
- By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
    - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
        e. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
        f. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or
    - An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
    - A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose

composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C.

254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or

- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
  - Have one or more serious chronic conditions;
  - Have a Serious Mental Illness;
  - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
  - Have a Serious Emotional Disturbance (children and adolescents);
  - Are receiving Enhanced Care Management; or
  - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or

- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically appropriate and cost-effective substitutes or settings for the State Plan service 2) beneficiaries are not required to use the in lieu of services, and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can only be approved one additional time with documentation as to what

conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service but it is not a requirement.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established

enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Clients who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers. When clients receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Short-term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides beneficiaries who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care.[23]

This setting provides individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management and beginning to access other housing supports such as Housing Transition Navigation.[24]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Beneficiaries must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[25]

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder

[23] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu service.
[24] Housing Transition/Navigation is a separate in-lieu service.
[25] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or

- Individuals who meet the definition of an individual experiencing chronic homelessness, either as defined:
    - In W&I Code section 14127(e) as "a homeless individual with a condition limiting his or her activities of daily living who has been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years." The definition also includes "an individual who is currently residing in transitional housing, as defined in Section 50675.2 of the Health and Safety Code, or who has been residing in permanent supportive housing as defined in Section 50675.14 of the Health and Safety Code for less than two years if the individual was chronically homeless prior to his or her residence.
    - By the Department of Housing and Urban Development (HUD) in 24 CFR 91.5 (including those exiting institutions but not including any limits on the number of days in the institution) as:
        - A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:
            g. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

            h. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as

described in paragraph (1) (i). Stays in institutional care facilities will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility; or

- An individual who has been residing in an institutional care facility, including a jail, substance use or mental health treatment facility, hospital, or other similar facility, and met all of the criteria in paragraph (1) of this definition, before entering that facility; or
- A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless; or

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
        - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

        - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
        - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
        - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;
    - (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
    - (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him; or
- Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a Serious Mental Illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder
    - Have a Serious Emotional Disturbance (children and adolescents);
    - Are receiving Enhanced Care Management; or
    - Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking, or
- Individuals who meet the State's No Place Like Home definition of "at risk of chronic homelessness", which includes persons exiting institutions that were homeless prior to entering the institution and Transition-age youth with significant

barriers to housing stability, including one or more convictions and history of foster care or involvement with the juvenile justice system.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are limited and are not to exceed a duration of six (6) months per episode (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems

- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) To Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transport services, skilled nursing facility services.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. It allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, such as transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing in lieu of services. Whenever possible, other housing in lieu of services should be provided to members onsite in the recuperative care facility. When enrolled in enhanced care management, in lieu of services should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for clients who are experiencing homelessness and who have complex health, disability, and/or behavioral health

conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [26]

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or setting for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Recuperative care/medical respite is an allowable in lieu of services service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support

[26] For this population, the service could be coordinated with home modifications (which are covered as a separate in lieu service) and serve as a temporary placement until the individual can safely return home

- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plan must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, skilled nursing facility, and emergency department services.

Respite Services

Description/Overview

Respite services are provided to caregivers of participants who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the participant's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

The Home Respite services are provided to the participant in his or her own home or another location being used as the home.

The Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, beneficiaries enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Clients with Complex Care Needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of service can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of service and 3) the in lieu of service is authorized and identified in the Medi-Cal managed care plan contracts.

In the home setting, these services, in combination with any direct care services the member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children

- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with Special Health Care Needs
- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, and skilled nursing or other institutional care.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a participant's home or an out-of-home, non-facility setting. The programs are designed to assist the participant in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For individuals experiencing homelessness who are receiving enhanced care management or other in lieu of services, the day habilitation program can provide a physical location for participants to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by clients and to improve overall care coordination and management.

Day habilitation program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to:

1. Selecting and moving into a home; [27]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords; [28]
5. Managing personal financial affairs;

[27] Refer to the Housing Transition/Navigation Services In Lieu of Services
[28] Refer to the Housing- Tenancy and Sustaining Services In Lieu of Services

6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;
9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link participant to any in lieu of services and/or enhanced care management services for which the client may be eligible;
11. Referral to non-in lieu of services housing resources if participant does not meet Housing Transition/Navigation Services in lieu of services eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/General Relief and SSI if client is not receiving these services through in lieu of services or enhanced care management; and
13. Coordination with Medi-Cal managed care plan to link participant to health care, mental health services, and substance use disorder services based on the individual needs of the participant for participants who are not receiving this linkage through in lieu of services or enhanced care management.

The services provided should utilize best practices for clients who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers
- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to: Inpatient and outpatient hospital services, skilled nursing facility, emergency department services.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

DESCRIPTION/OVERVIEW

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for beneficiaries with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the participant, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF); includes non-room and board costs (medical, assistance w/ ADLs.). Allowable expenses are those necessary to enable a person to establish a community facility residence that does not include room and board and includes:

1. Assessing the participant's housing needs and presenting options.[29]
2. Assessing the service needs of the participant to determine if the participant needs enhanced onsite services at the RCFE/ARF so the client can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of participants who need enhanced services to be safely and stably housed in RCFE/ARF settings have in lieu of services and/or enhanced care management services that provide the necessary enhanced services or fund RCFE/ARF operator directly to provide enhanced services.

[29] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
    1. Has resided 60+ days in a nursing facility;
    2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
    3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
    1. Interested in remaining in the community;
    2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
    3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive NF LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

Individuals are directly responsible for paying their own living expenses.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies

- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

The RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the participant's housing needs and presenting options.[30]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord, if applicable and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[31]
7. Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations. [32]

Eligibility (Population Subset)

[30] Refer to Housing Transition/Navigation Services In Lieu of Services for additional details.
[31] Refer to Home Modification In Lieu of Services for additional details.
[32] Refer to Housing Deposits In Lieu of Services for additional details.

1. Currently receiving medically necessary nursing facility LOC services and in lieu of remaining in, the nursing facility setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services;
2. Has lived 60+ days in a nursing home;
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $5,000.00. The only exception to the $5,000.00 total maximum is if the participant is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the participant, and without which the participant would be unable to move to the private residence and would then require continued or re-institutionalization.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to skilled nursing facility services.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADL) such as bathing, dressing, toileting, ambulation or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADL) such as meal preparation, grocery shopping and money management.

Services provided through the In-Home Support Services (In-Home Supportive Services) program include housecleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming and paramedical services), accompaniment to medical appointments and protective supervision for the mentally impaired.

Homemaker/Chore services include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care, Homemaker and Chore programs aids individuals who otherwise could not remain in their homes.

In lieu of services can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker in lieu of services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or

- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive Personal Care and Homemaker in lieu of services during this reassessment waiting period.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, skilled nursing facility.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare and safety of the individual, or enable the individual to function with greater independence in the home: without which the participant would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist beneficiaries in accessing the home;
- Doorway widening for beneficiaries who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the beneficiary; and
- Installation and testing of a Personal Emergency Response System (PERS) for persons who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the individual. For a home that is not owned by the individual, the individual must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as an in lieu of service, the managed care plan must receive and document an order from the participant's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the participant, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the participant describing how and why the equipment or service meets the needs of the individual will still be necessary.

For environmental accessibility adaptations, the managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should contain at least the following:

   A. An evaluation of the participant and the current equipment needs specific to the participant, describing how/why the current equipment does not meet the needs of the participant;

   B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the participant *and reduces the risk of institutionalization*. This should also include information on the ability of the participant and/or the primary caregiver to learn about and appropriately use any requested item, and

   C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the participant and a description of the inadequacy.

3. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

4. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $5,000. The only exceptions to the $5,000 total maximum are if the beneficiary's place of residence changes or if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare and safety of the beneficiary, or are necessary to enable the beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.
- Modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another

managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to nursing facility services, inpatient and outpatient hospital services, emergency department services and emergency transport services.

Meals/Medically Tailored Meals

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status and increased member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and side effects to ensure the best possible nutrition-related health outcomes.

4. Medically-supportive food and nutrition services, including medically tailored groceries and healthy food vouchers.

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate

and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- Up to three medically-tailored meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels providers

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify clients with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for clients who are homeless and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms) and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu

of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

This service is covered for a duration of less than 24 hours.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services, emergency department services, emergency transportation services.

Asthma Remediation[33]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the individual or their caregiver.

When authorizing asthma remediation as an in lieu of service, the managed care plan must receive and document:

1. The participant's current licensed health care provider's order specifying the requested remediation(s);
2. Depending on the type of remediation(s) requested, documentation from the provider describing how the remediation(s) meets the medical needs of the participant. A brief written evaluation specific to the participant describing how and why the remediation(s) meets the needs of the individual will still be necessary;
3. That a home visit has been conducted to determine the suitability of any requested remediation(s).

[33] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and ILOS should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

Asthma remediation includes providing information to individuals about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.
2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.
3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

In lieu of services are alternative services covered under the State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. In lieu of services can only be covered if: 1) the State determines they are medically-appropriate and a cost-effective substitutes or settings for the State plan service, 2) beneficiaries are not required to use the in lieu of services and 3) the in lieu of services is authorized and identified in the Medi-Cal managed care plan contracts.

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.
- Asthma remediations must be conducted in accordance with applicable State and local building codes.
- Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.
- Asthma remediations are payable up to a total lifetime maximum of $5,000. The only exception to the $5,000 total maximum is if the beneficiary's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the beneficiary, or are necessary to enable the

beneficiary to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma remediation modifications are limited to those that are of direct medical or remedial benefit to the beneficiary and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

- Before commencement of a physical adaptation to the home or installation of equipment in the home, the managed care plan must provide the owner and beneficiary with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the participant ceases to reside at the residence.

Individuals may not be receiving duplicative support from other State, local or federally funded programs, which should always be considered first, before using Medi-Cal funding.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- American Lung Association
- Allergy and Asthma Network
- National Environmental Education Foundation
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program. If there is no state-level enrollment pathway, managed care plans must enroll providers through their own established enrollment process, through the recognized enrollment process developed by another managed care plan, or, if applicable, through a state-level enrollment pathway established by another state department. Regardless of whether the providers are enrolled in Medi-Cal, managed care plans must credential the providers as required by DHCS.

State Plan Service(s) to Be Avoided

Examples of State Plan services to be avoided include but are not limited to inpatient and outpatient hospital services and emergency department services.

Glossary

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative is an "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees into managed care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexity and increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term

Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries in a COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the

2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, and community-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

In lieu of services: Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and an enrollee cannot be required to use them.

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical care for people with a chronic illness or disability. Long-term care services are those provided

to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, such as dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;
- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December 31, 2020, with approval pending to extend through calendar year 2021.

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

MICHELLE BAASS
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: November 5, 2021

ALL PLAN LETTER 21-017

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: COMMUNITY SUPPORTS REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding the provision of Community Supports, previously referred to as In Lieu of Services (ILOS), and the development and operation of these services by MCPs implementing Community Supports (ILOS). For the purposes of this APL, MCPs include Cal MediConnect Medicare-Medicaid Plans.

BACKGROUND:
The Department of Health Care Services (DHCS) released its California Advancing and Innovating Medi-Cal (CalAIM) proposal on October 29, 2019, in anticipation of the expiration of its Medi-Cal 2020 1115 Demonstration and 1915(b) Specialty Mental Health Services Waiver authorities. DHCS postponed the planned implementation of the CalAIM initiative, which was originally scheduled for January 1, 2021, due to the COVID-19 public health emergency, and released a revised CalAIM proposal on January 8, 2021. DHCS also submitted its CalAIM Section 1115 Demonstration and 1915(b) Waiver applications to the Centers for Medicare and Medicaid Services on June 30, 2021.[1] DHCS obtained statutory authority to establish the CalAIM initiative to support the stated goals of identifying and managing the risks and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes.[2]

CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reform across the Medi-Cal program. Community Supports (ILOS) are a key component of the CalAIM initiative that will be delivered through MCPs.

[1] Information regarding CalAIM, including updates regarding the implementation of various components of CalAIM, can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.
[2] Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021) can be accessed at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133.

Community Supports (ILOS) are medically appropriate and cost-effective alternatives to services covered under the State Plan. Community Supports (ILOS) are optional services for MCPs to provide and are optional for managed care members. These services are typically integrated into MCPs' population health management strategies. Community Supports (ILOS) will build on the Whole Person Care (WPC) Pilots and Health Homes Program (HHP) efforts and activities and expand access to services that were previously available only through home and community based services initiatives.[3,4] The WPC Pilots and HHP are scheduled to conclude on December 31, 2021.

MCPs may choose to offer Community Supports (ILOS) as cost-effective substitute for Medi-Cal covered services or settings including, but not limited to, emergency department visits, hospital or skilled nursing facility admission, or a discharge delay. To the extent a Member is receiving care or case management, Community Supports (ILOS) should be integrated with care or case management, including Enhanced Care Management (ECM) when appropriate, for Members. Use of Community Supports (ILOS) supports the goals of CalAIM by addressing the integrated medical and social determinants of health.

POLICY:
Effective January 1, 2022, all MCPs are encouraged to offer Community Supports (ILOS) to eligible Members. In particular, the following Community Supports (ILOS) have been pre-approved and authorized by DHCS in accordance with 42 Code of Federal Regulations (CFR) Section 438.3(e)(2), and may be offered and provided to eligible Members:

- Housing Transition Navigation Services;
- Housing Deposits;
- Housing Tenancy and Sustaining Services;
- Short-Term Post-Hospitalization Housing;
- Recuperative Care (Medical Respite);
- Respite Services;
- Day Habilitation Programs;
- Nursing Facility Transition/Diversion to Assisted Living Facilities;
- Community Transition Services/Nursing Facility Transition to a Home;
- Personal Care and Homemaker Services;
- Environmental Accessibility Adaptations (home modifications);

[3] The WPC Pilots webpage can be accessed at the following link: https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.
[4] The HHP webpage can be accessed at the following link: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.

- Medically Tailored Meals/Medically Supportive Food;
- Sobering Centers; and
- Asthma Remediation.

Subject to DHCS approval, MCPs may identify and propose additional Community Supports (ILOS) in order to provide medically appropriate, cost-effective services that are tailored to their Members' unique needs.

MCPs choosing to offer Community Supports (ILOS) must develop and submit an ILOS Model of Care, which is the MCP's framework for providing Community Supports (ILOS), including its policies and procedures for contracting with ILOS providers. The Model of Care must be completed and submitted in accordance with the Model of Care Template.[5] MCPs must contract with Community Supports (ILOS) providers to provide ILOS. In instances where MCPs are unable to contract with providers to offer Community Supports (ILOS), MCPs may provide these services through their existing network(s) with DHCS approval. MCPs are required to incorporate standard terms and conditions provided by DHCS, in addition to their own terms and conditions, to develop their contracts with Community Supports (ILOS) providers.[6]

MCPs offering any Community Supports (ILOS) must meet all program and reporting requirements specified by DHCS, applicable state and federal laws and regulations, and MCP contract requirements including full appeal rights. MCPs are expected to follow other DHCS guidance pertaining to Community Supports (ILOS), including but not limited to, future APLs or other supplementary guidance.

In future years for MCPs that satisfy Community Supports requirements, the utilization and cost data related to the pre-approved and authorized Community Supports (ILOS) will be taken into account in developing the component of the capitation rates that represents the State Plan Covered Services that are replaced by the Community Supports (ILOS), unless a statute or regulation explicitly requires otherwise, in accordance with 42 CFR Section 438.3(e)(2)(iv) and consistent with federal Medicaid managed care rate setting requirements.

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[5] The finalized Model of Care Template document, released in June 2021 and subject to any subsequent updates, is available on the ECM and ILOS webpage, which can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

[6] The finalized ECM and Community Supports (ILOS) Provider Standard Terms and Conditions document, released in June 2021 and subject to any subsequent updates, is available on the ECM and Community Supports (ILOS) webpage, which can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

MCPs must report all Community Supports (ILOS) encounters to DHCS, using the defined set of Community Supports (ILOS) Healthcare Common Procedure Coding System codes and modifiers.[7]

The Community Supports (ILOS) Policy Guide outlines Community Supports (ILOS) policies, including Member eligibility criteria, and contains DHCS' operational requirements and guidelines on Community Supports (ILOS). The Community Supports (ILOS) Policy Guide is posted on the DHCS ECM and Community Supports (ILOS) webpage.[8] DHCS may update the Community Supports (ILOS) Policy Guide to reflect the latest Community Supports (ILOS) requirements and guidelines. DHCS will notify MCPs when the Community Supports (ILOS) Policy Guide is updated.

Additionally, DHCS will issue supplemental information regarding Community Supports (ILOS) on a rolling basis through a frequently asked questions (FAQs) document. MCPs are encouraged to regularly check the ECM and Community Supports (ILOS) webpage for updates to the Community Supports (ILOS) FAQs document and other resources.[9]

MCPs are responsible for ensuring that all Community Supports (ILOS) providers, 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, and all other Community Supports (ILOS) requirements, must be communicated by each MCP to all Community Supports (ILOS) providers, subcontractors, and network providers.

[7] The finalized ECM and Community Supports (ILOS) Coding document, released in June 2021 and subject to any subsequent updates, is available on the ECM and Community Supports (ILOS) webpage, which can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[8] The Community Supports (ILOS) Policy Guide is available on the ECM and Community Supports (ILOS) webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[9] ECM and Community Supports (ILOS) FAQs and additional program information are available on the ECM and Community Supports (ILOS) webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager and the DHCS CalAIM mailbox at CalAIM@dhcs.ca.gov.

Sincerely,

Original Signed by Dana Durham

Dana Durham, Chief
Managed Care Quality and Monitoring Division

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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: September 15, 2021

ALL PLAN LETTER 21-012

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: ENHANCED CARE MANAGEMENT REQUIREMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to all Medi-Cal managed care health plans (MCPs) regarding the provision of the Enhanced Care Management (ECM) benefit.

BACKGROUND:
The Department of Health Care Services (DHCS) released its California Advancing and Innovating Medi-Cal (CalAIM) proposal on October 29, 2019, in anticipation of the expiration of its Medi-Cal 2020 1115 Demonstration and 1915(b) Specialty Mental Health Services Waiver authorities. DHCS postponed the planned implementation of the CalAIM initiative, which was originally scheduled for January 1, 2021, due to the COVID-19 public health emergency, and released a revised CalAIM proposal on January 8, 2021. DHCS also submitted its CalAIM Section 1115 Demonstration and 1915(b) Waiver applications to the Centers for Medicare and Medicaid Services on June 30, 2021.[1] DHCS obtained statutory authority to establish the CalAIM initiative to support the stated goals of identifying and managing the risks and needs of Medi-Cal beneficiaries, transitioning and transforming the Medi-Cal program to a more consistent and seamless system, and improving quality outcomes.[2]

CalAIM is a multi-year initiative to improve the quality of life and health outcomes of the Medi-Cal managed care population through the implementation of broad delivery system, program, and payment reforms across the Medi-Cal program. The ECM benefit is a component of the CalAIM initiative that will be delivered through Medi-Cal managed care.

[1] Information regarding CalAIM, including updates regarding the implementation of various components of CalAIM, can be found at: https://www.dhcs.ca.gov/provgovpart/Pages/CalAIM.aspx.
[2] Assembly Bill 133 (Committee on Budget, Chapter 143, Statutes of 2021) can be accessed at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=202120220AB133.

ECM is a whole-person, interdisciplinary approach to comprehensive care management intended to address the clinical and non-clinical needs of high-cost, high-need managed care members through systematic coordination of services that is community-based, interdisciplinary, high-touch, and person-centered. ECM will build on the Whole Person Care (WPC) Pilots and Health Homes Program (HHP) efforts and activities.[3,4] The care coordination and care management services that are currently being provided under WPC Pilots and HHP will transition to and be replaced by ECM. The ECM benefit will be phased in over time and available statewide through the managed care delivery system starting January 1, 2022. The WPC Pilots and HHP are scheduled to conclude on December 31, 2021.

POLICY:
Effective upon the DHCS determined ECM implementation date for each MCP in its respective county of operation, the MCP must administer ECM and provide the following seven core ECM services to eligible Members in applicable ECM Populations of Focus: 1) Outreach and Engagement; 2) Comprehensive Assessment and Care Management Plan; 3) Enhanced Coordination of Care; 4) Health Promotion; 5) Comprehensive Transitional Care; 6) Member and Family Supports; and 7) Coordination of and Referral to Community and Social Support Services.[5]

ECM Core Service Components:

The requirements under each core service component are described below.

1) Outreach and Engagement:

a. The MCP is responsible for reaching out to and engaging Members who are identified to be eligible for ECM.

[3] The WPC Pilots webpage can be accessed at the following link: https://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx.
[4] The HHP webpage can be accessed at the following link: https://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx.
[5] The ECM and In Lieu of Services (ILOS) implementation timelines are available in the ECM and ILOS Model of Care Cover Note, released in June 2021, and subject to any subsequent updates, which is available on the ECM and ILOS webpage at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

2) **Comprehensive Assessment and Care Management Plan**, which must include, but is not limited to:
   a. Engaging with each Member authorized to receive ECM, primarily through in-person contact;
      i. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.
   b. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan;
   c. Developing a comprehensive, individualized, person-centered Care Management Plan with input from the Member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as appropriate, to assess strengths, risks, needs, goals and preferences and make recommendations for service needs;
   d. Incorporating into the Member's Care Management Plan identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental health, dementia, substance use disorders (SUD), Long Term Services and Supports (LTSS), oral health, palliative care, necessary community-based and social services, and housing;
   e. Ensuring the Member is reassessed at a frequency appropriate for the Member's individual progress, changes in needs, and/or as identified in the Care Management Plan; and
   f. Ensuring the Care Management Plan is reviewed, maintained, and updated under appropriate clinical oversight.

3) **Enhanced Coordination of Care**, which must include, but is not limited to:
   a. Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan;
   b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team since their input is

necessary for successful implementation of the Member's goals and needs;

c. Ensuring care is continuous and integrated among all service Providers and refers to and follows up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed;
d. Providing support to engage the Member in their treatment, including coordination for medication review and reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment;
e. Communicating the Member's needs and preferences timely to the Member's multi-disciplinary care team in a manner that ensures safe, appropriate, and effective person-centered care; and
f. Ensuring regular contact with the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as appropriate, consistent with the Care Management Plan.

4) **Health Promotion**, which must include, but is not limited to:
a. Working with the Member to identify and build on successes and potential family and/or support networks;
b. Providing services to encourage and support the Member to make lifestyle choices based on healthy behavior, with the goal of supporting the Member's ability to successfully monitor and manage their health; and
c. Supporting the Member in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

5) **Comprehensive Transitional Care**, which must include, but is not limited to:
a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM;
b. For Members who are experiencing or are likely to experience a care transition:
    i. Developing and regularly updating a transition plan for the Member;
    ii. Evaluating the Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions to,

from, and among treatment facilities, including admissions and discharges;

iii. Tracking each Member's admission and discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members;

iv. Coordinating medication review and reconciliation; and

v. Providing adherence support and referral to appropriate services.

6) **Member and Family Supports**, which must include, but are not limited to:

a. Documenting the Member's authorized family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as applicable;

b. Ensuring all required authorizations are in place to ensure effective communication between the ECM Providers, MCP, and the Member and their family members, authorized representatives, legal guardians, caregivers, and authorized support persons, as applicable;

c. Activities to ensure the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, are knowledgeable about the Member's conditions, with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws;

d. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and their family members, legal guardians, authorized representatives, caregivers, and other authorized support persons, as applicable;

e. Identifying supports needed for the Member and/or their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, to manage the Member's condition and assist them in accessing needed support services;

f. Providing appropriate education for the Member and their family members, legal guardians, authorized representatives, caregivers, and/or authorized support persons, as applicable, about care instructions for the Member; and,

g. Ensuring that the Member and their family members, legal guardians, authorized representatives, caregivers, and authorized support persons, as applicable, have a copy of the Member's Care Management Plan and information about how to request updates.

7) **Coordination of and Referral to Community and Social Support Services**, which must include, but is not limited to:
   a. Determining appropriate services to meet the needs of the Member, including services that address social determinants of health needs, such as housing, and services offered by the MCP as ILOS; and
   b. Coordinating and referring the Member to available community resources and following up with the Member to ensure services were rendered (i.e., "closed loop referrals").

Additional Guidance:

ECM Populations of Focus (POF)
MCPs must proactively identify and offer ECM to their high-need, high-cost Members who meet the POF criteria listed in the Contract and detailed in Attachment 1 of this APL.

ECM Provider Standard Terms and Conditions (STCs)
MCPs must ensure ECM is provided primarily through in-person interaction in settings that are most appropriate for Members and, to this end, must contract with ECM Providers to provide ECM services in a community based, in-person manner. MCPs are required to incorporate STCs provided by DHCS, in addition to their own terms, to develop their contracts with ECM Providers.[6]

ECM Model of Care (MOC)
MCPs must develop and submit to DHCS for review and approval an ECM MOC, which is the MCP's framework for providing ECM. MCPs must complete and submit their MOCs in accordance with the DHCS approved MOC Template.[7] MCPs must submit to DHCS any significant updates to their MOCs for DHCS review and approval at least 60 calendar days in advance of significant changes or updates. Significant changes may include, but are not limited to, changes to the MCP's approach to administer or deliver ECM services, approved P&Ps, and Subcontractor Agreement(s) boilerplates.

ECM Encounter Data Reporting
MCPs must report all ECM encounters to DHCS, using the defined set of ECM

[6] The finalized ECM and ILOS Provider STCs document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[7] The finalized MOC Template document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.

Healthcare Common Procedure Coding System codes and modifiers.[8]

ECM Policy Guide

The ECM Policy Guide outlines ECM policies and contains details of MCPs' contractual requirements for ECM. The ECM Policy Guide includes operational guidelines, including reporting requirements for ECM. MCPs must use the ECM Policy Guide as a key resource for implementation and administration of ECM. The ECM Policy Guide is posted to the ECM and ILOS webpage.[9] The ECM Policy Guide also contains information related to MCPs' use of DHCS ECM/ILOS Billing & Invoicing Guidance as well as ECM Member Information File Guidance. DHCS may update the ECM Policy Guide to reflect the latest ECM requirements and guidelines. DHCS will notify MCPs whenever the ECM Policy Guide is updated.

ECM Rates:

For the Calendar Year 2022 rating period, a two-sided, symmetrical risk corridor will be in effect for applicable revenues and expenditures associated with ECM, as determined by DHCS. Further details of this risk corridor will be incorporated into this APL via a subsequent revision, or into the Contract via an amendment. DHCS reserves the right to continue the risk corridor for subsequent rating periods, subject to actuarial judgment and consultation with affected MCPs.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, ECM requirements, contract requirements, and other DHCS guidance, including APLs and Policy Letters.[10] These requirements must be communicated by each MCP to all Subcontractors and Network Providers.

[8] The finalized ECM and ILOS Coding Options document, released in June 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[9] The ECM Policy Guide released in September 2021, and subject to any subsequent updates, is available on the ECM and ILOS webpage that can be accessed at the following link: https://www.dhcs.ca.gov/Pages/ECMandILOS.aspx.
[10] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

If you have any questions regarding this APL, please contact your MCOD Contract Manager and the DHCS CalAIM mailbox at CalAIM@dhcs.ca.gov.

Sincerely,

Original signed by Bambi Cisneros

Bambi Cisneros, Acting Chief
Managed Care Quality and Monitoring Division

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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

CalAIM Enhanced Care Management Policy Guide

September 2021

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I. Introduction

This California Advancing and Innovating Medi-Cal (CalAIM) Enhanced Care Management (ECM) Policy Guide is intended to serve as a resource for Medi-Cal Managed Care health plans (MCPs) in the implementation of ECM. The Policy Guide provides a comprehensive overview of ECM as well as additional operational guidance for MCPs as they prepare to offer ECM beginning in 2022.

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal Members by implementing broad delivery system, program and payment reform across the Medi-Cal program. A key feature of CalAIM is the statewide introduction of an ECM benefit and a menu of in lieu of services (ILOS), which, at the option of an MCP and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering both ECM and ILOS.

ECM and ILOS have been developed from lessons learned, as well as MCP and Provider experience, in the Whole Person Care (WPC) Pilots and Health Homes Program (HHP). Both WPC and HHP led the way in providing a set of intensive care coordination services that spanned multiple delivery systems to provide a person-centered approach to care. These initiatives also pushed the boundaries of a traditional health care delivery approach to begin formally considering the impact of Social Determinants of Health (SDOH) on health outcomes and experience of care in California's Medicaid program.

DHCS' adoption of ECM and ILOS on a statewide scale will support the highest-need MCP Members, with the provision of ECM and ILOS anchored in the community, where services can be delivered in an in-person manner by community-based ECM and ILOS Providers, to the greatest extent possible.

DHCS' requirements for MCPs to implement ECM and ILOS are contained in the ECM All Plan Letter (APL), ECM and ILOS Contract Template (ECM and ILOS Contract), which will become part of the MCPs' contract with DHCS, and the DHCS' ECM and ILOS Standard Provider Terms and Conditions.[1] ECM and ILOS are separate initiatives, and some Medi-Cal Members will qualify for only ECM or only ILOS.

The combination of ECM and ILOS represents an opportunity for MCPs to work with Providers, counties and community-based organizations (CBOs) to deliver a strong set of integrated supports for those who need them most.

As part of the implementation and ongoing administration of ECM and ILOS, each MCP will be required to develop and submit for DHCS approval an ECM and ILOS Model of Care (MOC). The MOC will be each MCP's detailed plan for providing ECM and ILOS in accordance with DHCS' requirements. Each MCP's MOC will include its overall approach to ECM and ILOS; its detailed policies and procedures for partnering with Providers, including non-traditional Medi-Cal

[1] Refer to the DHCS-MCP ECM and ILOS Contract and DHCS MMCD Boilerplate Contracts for definitions of capitalized terms within this document.

Providers, for the administration of ECM and ILOS; its ECM and ILOS Provider capacity; and the contract language that will define its arrangements with its ECM and ILOS Providers.

This Policy Guide is intended to serve as a resource for MCPs preparing to offer ECM, as well as for other key stakeholders involved in ECM, such as Providers, counties and CBOs. Updates will be published as needed and posted on the ECM and ILOS webpage, where stakeholders can also find other resources, including FAQs. MCPs and other stakeholders may direct their questions to DHCS using the following email address: CalAIMECMILOS@dhcs.ca.gov.

II. What Is Enhanced Care Management (ECM)?

ECM is a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of Members with the most complex medical and social needs through systematic coordination of services and comprehensive care management that is community based, interdisciplinary, high touch and person centered. DHCS' vision for ECM is to coordinate all care for Members who receive it, including across the physical and behavioral health delivery systems. ECM is a Medi-Cal benefit that will be phased into each county, according to the schedule in Section III below.

DHCS has long understood that the need for care management and coordination increases with clinical and social complexity and has worked for several years to build capacity for a more comprehensive approach to care management and coordination in Medi-Cal. In 2016, DHCS launched the WPC Pilots as part of its Medi-Cal 2020 Section 1115 Demonstration. WPC Pilots have tested interventions to coordinate physical, behavioral and social services in a patient-centered manner, including interventions that address SDOH such as improving access to housing and supportive services, and have built significant infrastructure to ensure local collaboration for improved outcomes. In 2018, DHCS launched the Health Homes Program (HHP). The HHP serves eligible Medi-Cal Members with complex medical needs and chronic conditions who may benefit from intensive care management and coordination, and coordinates the full range of physical health, behavioral health and community-based long-term services and supports (LTSS).

ECM builds on both the design and the learning from the WPC Pilots and the HHP. ECM, with ILOS, will replace both initiatives, scaling up the interventions to form a statewide care management approach. ECM will offer comprehensive, whole person care management to high-need, high-cost Medi-Cal Managed Care Members, with the overarching goals of:

- Improving care coordination;
- Integrating services;
- Facilitating community resources;
- Addressing SDOH;
- Improving health outcomes; and
- Decreasing inappropriate utilization and duplication of services.

ECM is part of a broader population health strategy design within CalAIM, under which MCPs will systematically risk-stratify their enrolled populations and offer a menu of care management interventions at different levels of intensity, with ECM at the highest intensity level. ECM will be implemented ahead of broader population health strategy requirements, which will start in 2023.

III. ECM Implementation Timeline

ECM will be phased in by county and Population of Focus from January 2022, through July 2023, beginning with counties that have participated in WPC and HHP. All MCPs in all counties may launch ILOS starting in January 2022. MCPs operating in HHP and WPC counties are expected to build upon the experience gained in HHP and WPC and to design a transition approach that maximizes continuity of services for their Members transitioning from HHP and WPC. **See Appendix A for counties participating in WPC Pilots and HHP**.

ECM is a Managed Care benefit and will be accounted for in MCP capitation rates; thus, once an ECM Population of Focus goes live in a particular county, MCPs must provide ECM to eligible Members if they request it. However, DHCS recognizes that ECM Provider network development will take time and expects MCPs to expand ECM network capacity over the first 12 months for each Population of Focus, and this assumption will be reflected in the MCP rates. For comprehensive details about the Populations of Focus, please refer to the next section.

ECM Implementation Timeline for Counties with Health Home Program Participation

On January 1, 2022, in HHP counties, ECM goes live for the following ECM Populations of Focus:

- Individuals and Families Experiencing Homelessness;
- High Utilizer Adults; and
- Adults with SMI/SUD.

MCPs are required to automatically transition and authorize ECM for Members currently being served by HHP, or in the process of enrolling in HHP, and are strongly encouraged to offer appropriate ILOS to these Members on January 1, 2022, including ILOS that align with services currently offered under HHP. Within six months of these Members transitioning to ECM, the MCP must ensure that each Member is reassessed to determine the most appropriate level of care management or coordination of services, whether ECM or a lower level of care management or coordination. MCPs should assess transitioning HHP Members using their ECM discontinuation criteria as outlined in Section 11.a of the Finalized DHCS-MCP ECM and ILOS Contract Template. MCPs operating in HHP counties must describe in their MOC how they will sustain current HHP services through a combination of ECM and ILOS; adoption of ILOS to continue services available under HHP is strongly encouraged.

On January 1, 2023, MCPs will expand ECM to the following Populations of Focus in HHP counties:

- Individuals Transitioning from Incarceration (adults and children/youth);
- Members Eligible for LTC and at Risk of Institutionalization; and
- Nursing Home Residents Transitioning to the Community.

Children and Youth Populations of Focus in HHP counties will begin receiving ECM on July 1, 2023. A complete implementation schedule is listed below.

Figure 1: ECM and ILOS Implementation Timeline for MCPs in HHP Counties

Date	Health Home Program (HHP) Counties

January 1, 2022	• Transition and automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in HHP
	• ECM goes live for all of the following ECM Populations of Focus:
	  ○ *Individuals and Families Experiencing Homelessness;*
	  ○ *High Utilizer Adults; and*
	  ○ *Adults with SMI/SUD.*
	
	To ensure no interruption in service, children and youth currently served by HHP will be transitioned into ECM and reassessed within six months.

	ILOS goes live for all counties

January 1, 2023	• ECM goes live for the following ECM Populations of Focus:
	  ○ *Individuals Transitioning from Incarceration (adults and children/youth);*
	  ○ *Members Eligible for LTC and at Risk of Institutionalization; and*
	  ○ *Nursing Home Residents Transitioning to the Community.*

July 1, 2023	• ECM goes live for *all Children and Youth*

ECM Implementation Timeline for Counties with WPC Pilots

On January 1, 2022, in WPC Pilot counties, ECM goes live for the following ECM Populations of Focus:

- Individuals and Families Experiencing Homelessness;
- High Utilizer Adults; and
- Adults with SMI/SUD.

MCPs are required to automatically authorize and transition individual Members currently enrolled in WPC who are identified by the WPC Lead Entity in the county as currently receiving Care Coordination services in the pilot, and are strongly encouraged to offer appropriate ILOS to these Members beginning on January 1, 2022. Within six months of these Members transitioning to ECM, the MCP must ensure that each Member is reassessed to determine the most appropriate level of care management or coordination of services, whether ECM or a lower level of care management or coordination. MCPs should assess transitioning WPC Members using their ECM discontinuation criteria as outlined in Section 11.a of the Finalized DHCS-MCP ECM and ILOS Contract Template. MCPs operating in WPC Pilot counties must describe in their MOC how they will sustain WPC services through a combination of ECM and ILOS; adoption of ILOS to continue services available under WPC Pilots is strongly encouraged.

DHCS recognizes that the current WPC Pilots vary in the level of data sharing between WPC Lead Entities and MCPs. To support transition of Members between WPC and ECM, DHCS will work with WPC Lead Entities to create transition rosters in the second half of 2021 to identify enrollees who should transition to ECM.

On January 1, 2023, MCPs will expand ECM to the following Populations of Focus in WPC Pilot counties:

- Individuals Transitioning from Incarceration (adults and children/youth);
- Members Eligible for LTC and at Risk of Institutionalization; and
- Nursing Home Residents Transitioning to the Community.

Children and Youth Populations of Focus will begin receiving ECM on July 1, 2023. A complete implementation schedule is listed below.

Figure 2: ECM and ILOS Implementation Timeline for MCPs in WPC Pilot Counties

Date	Whole Person Care (WPC) Pilot Counties
January 1, 2022	• Transition and automatically authorize ECM for all Members of ECM Populations of Focus who are enrolled in or are in the process of being enrolled in WPC who are currently receiving Care Coordination services through the pilot. • ECM goes live for all of the following ECM Populations of Focus: ○ *Individuals and Families Experiencing Homelessness;* ○ *High Utilizer Adults; and* ○ *Adults with SMI/SUD.* *To ensure no interruption in service, children and youth currently served by HHP or WPC will be transitioned into ECM and reassessed within six months.*
	ILOS goes live for all counties
January 1, 2023	ECM goes live for the following ECM Populations of Focus: ○ *Individuals Transitioning from Incarceration (adults and children/youth) in **all remaining counties**;* ○ *Members Eligible for LTC and at risk of Institutionalization; and* ○ *Nursing Home Residents Transitioning to the Community.*
July 1, 2023	ECM goes live for all other *Children and Youth*.

ECM Implementation Timeline for Counties without HHP or WPC Pilots

Beginning July 1, 2022, MCPs are required to implement ECM in counties without HHP or WPC Pilots for the following ECM Populations of Focus:

- Individuals and Families Experiencing Homelessness;
- High Utilizer Adults; and
- Adults with SMI/SUD.

All MCPs are strongly encouraged to offer ILOS in all counties beginning on January 1, 2022.

On January 1, 2023, MCPs will expand ECM to the following Populations of Focus:

- Individuals Transitioning from Incarceration (adults and children/youth);

- Members Eligible for LTC and at Risk of Institutionalization; and
- Nursing Home Residents Transitioning to the Community.

Children and Youth Populations of Focus will begin receiving ECM on July 1, 2023. A complete implementation schedule is listed below.

Figure 3: ECM and ILOS Implementation Timeline for <u>MCPs in Counties with Neither</u> HHP nor WPC Pilots

Date	Counties with Neither HHP nor WPC Pilots
January 1, 2022	
July 1, 2022	ECM goes live for the following ECM Populations of Focus: ○ *Individuals and Families Experiencing Homelessness;* ○ *High Utilizer Adults; and* ○ *Adults with SMI/SUD.* Each MCP must describe in the MOC how it will grow its network capacity to serve each Population of Focus over the first 12 months of implementation (July 2022-July 2023).
January 1, 2023	ECM goes live for the following ECM Populations of Focus: ○ *Individuals Transitioning from Incarceration (adults and children/youth);* ○ *Members Eligible for LTC and at Risk of Institutionalization; and* ○ *Nursing Home Residents Transitioning to the Community.*
July 1, 2023	ECM goes live for all other *Children and Youth*.

IV. ECM Populations of Focus

To be eligible for ECM, Members must be enrolled in Medi-Cal Managed Care and meet the criteria provided below in each of the Populations of Focus definitions. DHCS has created distinct Populations of Focus definitions for adults and children/youth.

The Populations of Focus definitions given below update and replace the definitions described in the CalAIM Proposal of January 2021. For additional guidance and examples of services for each of the Populations of Focus, please refer to Appendix B.

Children and Youth Populations of Focus

Populations of Focus for Children and Youth include the following:

1. Children (up to Age 21) experiencing homelessness;
2. High utilizers;
3. Serious Emotional Disturbance (SED) or identified to be at Clinical High Risk (CHR) for Psychosis or Experiencing a First Episode of Psychosis;
4. Enrolled in California Children's Services (CCS)/CCS Whole Child Model (WCM) with additional needs beyond the CCS qualifying condition;
5. Involved in, or with a history of involvement in, child welfare (Including Foster Care up to Age 26); and
6. Transitioning from incarceration.

Definitions and detailed eligibility criteria for the Children and Youth Populations of Focus are forthcoming.

Adult Populations of Focus

Population of Focus #1:
Individuals and Families Experiencing Homelessness

Individuals who:

(1) are experiencing homelessness (as defined below)

AND

(2) have at least one complex physical, behavioral or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes **and/or** decreased utilization of high-cost services.

An Individual or Family Experiencing Homelessness is defined as:

- An individual or family who lacks adequate nighttime residence;
- An individual or family with a primary residence that is a public or private place not designed for or ordinarily used for habitation;
- An individual or family living in a shelter;
- An individual exiting an institution into homelessness;
- An individual or family who will imminently lose housing in next **30 days**;
- Unaccompanied youth and homeless families and children and youth defined as homeless under other federal statutes; or
- Individuals fleeing domestic violence.

Notes on the definition:

- This definition is taken from the US Department of Housing and Urban Development (HUD) definition of "Homeless"[2] with the following modifications:
  - If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of the institutionalization.
  - The timeframe for an individual or family who will imminently lose housing has been extended from 14 days (HUD definition) to 30 days.

Examples of eligible MCP Members under this Population of Focus:

- Members experiencing homelessness with complex health care needs as a result of an unmanaged medical, psychiatric or SUD-related condition.

- Members with complex health care needs as a result of a medical, psychiatric or SUD-related condition, who have recently received an eviction notice and will imminently lose housing in the next 30 days.

[2] HUD Definition of Homelessness 42 U.S. Code § 11302 - General definition of homeless individual. https://www.govinfo.gov/app/details/USCODE-2010-title42/USCODE-2010-title42-chap119-subchapI-sec11302.

Population of Focus #2:
Adult High Utilizers

Adults with:
(1) **five or more** emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

AND/OR

(2) **three or more** unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

MCPs may also authorize ECM for other individuals with a pattern of very high utilization that could have been avoided with appropriate care or improved treatment adherence.

Notes on the definition:

- The definition allows MCPs to authorize ECM services for very high utilizer individuals who would benefit from ECM but who may not meet numerical thresholds (1) and/or (2).
- However, this flexibility does not displace the numerical thresholds provided in the definition to identify high utilizers. MCPs must use the numerical thresholds to identify Members in this Population of Focus. MCPs should have a consistent approach (e.g., algorithms or other methodologies) for identifying high utilizers and should describe it in their Model of Care Template submission to DHCS.
- MCPs should utilize a "rolling" six-month lookback period based on the most recent month of adjudicated claims data.
- ED visits that result in an inpatient stay should only count as one inpatient visit.

Examples of eligible MCP Members under this Population of Focus:

- Members with repeated incidents of avoidable emergency room visits in a six-month period, who have a medical, psychiatric or SUD-related condition requiring intensive coordination beyond telephonic intervention.

- Members with repeated incidents of avoidable emergency room visits in a six-month period who have significant functional limitations and/or adverse social determinants of health that impede them from navigating their health care and other services.

Population of Focus #3:
Adult SMI/SUD

Adults who:
(1) **meet the eligibility criteria** for participation in or obtaining services through:
- The county Specialty Mental Health (SMH) System **AND/OR**
- The Drug Medi-Cal Organization Delivery System (DMC-ODS) **OR** the Drug Medi-Cal (DMC) program.

AND
(2) are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of Adverse Childhood Experiences (ACEs), former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors);
AND
(3) **meet one or more of the following criteria:**
- are at high risk for institutionalization, overdose and/or suicide;
- Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care;
- experienced two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months; or
- are pregnant or post-partum women (12 months from delivery).

Notes on the definition:
Institutionalization in this context is broad and means any type of inpatient, SNF, long-term or emergency department setting.

Examples of eligible MCP Members under this Population of Focus:

- Members who have the highest levels of complex health care needs as a result of psychiatric or SUD-related conditions, who are experiencing one complex social factor influencing their health and are pregnant.

- Former foster youth Members with a psychiatric or SUD-related condition, who are currently using emergency rooms as the sole source of care.

Population of Focus #4:
Individuals Transitioning from Incarceration

Individuals who:
(1) are transitioning from incarceration or transitioned from incarceration within the past 12 months

AND

(2) have at least one of the following conditions:

- Chronic mental illness
- Substance Use Disorder (SUD)
- Chronic disease (e.g., hepatitis C, diabetes)
- Intellectual or developmental disability
- Traumatic brain injury
- HIV
- Pregnancy

Notes on the definition:

- The conditions listed above align with the eligibility criteria for pre-release coverage in California's 1115 Demonstration Amendment and Renewal Application as of the date of publication of this Guide. The waiver is not yet final, and thus the above criteria are subject to change.

Population of Focus #5:
Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services

Individuals at risk for institutionalization who are eligible for Long-Term Care services who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF). Individuals must be able to live safely in the community with wraparound supports.

Examples of eligible MCP Members under this Population of Focus:

- Individuals in need of increasing assistance with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).
- Possibly, individuals with changes to family or caregiver status.
- Possibly, individuals with medical or surgical setbacks resulting in a decrease in functional, cognitive or psychological status.
- Possibly, individuals showing early signs of dementia with few or no natural supports.
- Possibly, individuals who are noncompliant with their prescribed medical regime.
- Possibly, individuals who are not appropriately engaged to take advantage of necessary health care services.
- Possibly, individuals who lack a family or community support system to assist in appropriate follow-up care at home.

Population of Focus #6:
Nursing Facility Residents Who Want to Transition to the Community

Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so.

Notes on the definition:

- **Individuals should be:**
  - Interested in moving out of the institution.
  - Medically appropriate to live in the community.
  - Able to reside safely in the community.

V. Core Service Components of ECM

Overview of ECM Core Service Components

The goal of ECM is to coordinate all primary, acute, behavioral, developmental, oral, social needs, and long-term services and supports for Members, including participating in the care planning process, regardless of setting. ECM activities should become integrated with other care coordination processes and functions, and in most cases, the ECM Provider must assume primary responsibility for coordination of the Member's needs, including collaboration with other coordinators who operate in a more limited scope.

ECM is intended to be interdisciplinary, high touch, person centered and provided primarily through in-person interactions with Members where they live, seek care and prefer to access services. Members who will be eligible for ECM are expected to be among the most vulnerable and highest-need Medi-Cal Managed Care Members. It will be critical for ECM Providers to establish strong relationships with these Members, and this will occur most effectively through in-person interactions. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider is permitted to use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.

This section describes the seven ECM core services. The core components of ECM that are universal for all Populations of Focus include (1) Outreach and Engagement; (2) Comprehensive Assessment and Care Management Plan; (3) Enhanced Coordination of Care; (4) Health Promotion; (5) Comprehensive Transitional Care; (6) Member and Family Supports; and (7) Coordination of and Referral to Community and Social Support Services. Notably, the nuances of supports and services provided through ECM will vary based on the needs of the Member. **Appendix B** contains detailed examples of interventions that ECM may support for each unique Population of Focus.

1) Outreach and Engagement

MCPs are responsible for identifying (or accepting referrals for) Members who are eligible for ECM. MCPs will then assign every Member authorized for ECM to an ECM Provider. ECM Providers are responsible for reaching out to, and engaging, assigned Members.

MCPs must develop comprehensive outreach Policies and Procedures as part of the MOC. Activities in the Outreach and Engagement core service can include, but are not limited to:

a. Attempting to locate, contact and engage Members who have been identified as good candidates to receive ECM services, promptly after assignment.
b. Using multiple strategies for engagement, as appropriate and to the extent possible, including direct communications with the Member, such as in-person meetings where the Member lives, seeks care or is accessible; mail, email, texts and telephone; community and street-level outreach; follow-up if the Member presents to another partner in the ECM network; or using claims data to contact Providers the Member is known to use.

c. Using an active and progressive approach to outreach and engagement until the Member is engaged.
d. Documenting outreach and engagement attempts and modalities.
e. Utilizing educational materials and scripts developed for outreaching and engaging Members, as appropriate.
f. Sharing information between the MCP and ECM Providers, to ensure that the MCP can assess Members for other programs if they cannot be reached or decline ECM.
g. Providing culturally and linguistically appropriate communications and information to engage Members.

2) Comprehensive Assessment and Care Management Plan

After the initial step of successful engagement with an ECM Member, a comprehensive assessment should be conducted and a care plan developed. This process involves the ECM Members and their family/support persons as well as appropriate clinical input in developing a comprehensive, individualized, person-centered care plan. The care plan is based on the needs and desires of the Member and should be reassessed based on the Member's individual progress or changes in their needs and/or as identified in the care plan. The care plan incorporates the Member's needs in the areas of physical health, mental health, SUD, community-based LTSS, oral health, palliative care, social supports and SDOH. Comprehensive care management may include case conferences to ensure that the Member's care is continuous and integrated among all service Providers.

Activities in the Comprehensive Assessment and Care Management Plan core service must include, but are not limited to:

a. Engaging with each Member authorized to receive ECM primarily through in-person contact.

b. When in-person communication is unavailable or does not meet the needs of the Member, the ECM Provider must use alternative methods (including innovative use of telehealth) to provide culturally appropriate and accessible communication in accordance with Member choice.

c. Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care, and may be needed to inform the development of an individualized Care Management Plan.

d. Developing a comprehensive, individualized, person-centered care plan with input from the Member and/or their family member(s), guardian, AR, caregiver and/or other authorized support person(s) as appropriate to assess strengths, risks, needs, goals and preferences and make recommendations for service needs.

e. In the Member's care plan, incorporating identified needs and strategies to address those needs, including, but not limited to, physical and developmental health, mental

health, dementia, SUD, LTSS, oral health, palliative care, necessary community-based and social services, and housing.

f. Ensuring the Member is reassessed at a frequency appropriate for the Member's individual progress or changes in needs and/or as identified in the Care Management Plan.

g. Ensuring the Care Management Plan is reviewed, maintained and updated under appropriate clinical oversight.

3) Enhanced Coordination of Care

Enhanced Coordination of Care includes the services necessary to implement the care plan. Enhanced Coordination of Care services must include, but are not limited to:

a. Organizing patient care activities, as laid out in the Care Management Plan; sharing information with those involved as part of the Member's multi-disciplinary care team; and implementing activities identified in the Member's Care Management Plan.

b. Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs. Enhanced Coordination of Care may include case conferences in order to ensure that the Member's care is continuous and integrated among all service Providers.

c. Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, LTSS, oral health, palliative care, and necessary community-based and social services, including housing, as needed.

d. Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.

e. Communicating the Member's needs and preferences in a timely manner to the Member's multi-disciplinary care team in an effort to ensure safe, appropriate and effective person-centered care.

f. Ensuring regular contact with the Member and their family member(s), guardian, AR, caregiver and/or authorized support person(s), when appropriate, consistent with the care plan and to ensure information is shared with all involved parties to monitor the Member's conditions, health status, care planning, medications usages and side effects.

4) Health Promotion

Health Promotion includes services to encourage and support Members receiving ECM to make lifestyle choices based on healthy behavior, with the goal of motivating Members to successfully monitor and manage their health. Health Promotion services can include, but are not limited to:

a. Working with Members to identify and build on successes and potential family and/or support networks.

b. Providing services, such as coaching, to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health.

c. Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

d. Linking Members to resources for smoking cessation, management of Member chronic conditions, self-help recovery resources and other services based on Member needs and preferences.

e. Using evidence-based practices, such as motivational interviewing, to engage and help the Member participate in and manage their care.

5) Comprehensive Transitional Care

Comprehensive Transitional Care includes services intended to support ECM Members and their families and/or support networks during discharge from hospital and institutional settings. Services include facilitating ECM Members' transitions from and among treatment facilities, including admissions and discharges. Additionally, MCPs or ECM Providers should provide information to hospital discharge planners about ECM so that collaboration on behalf of the Member can occur in as timely a manner as possible. Comprehensive Transitional Care can help avoid unnecessary readmissions.

Comprehensive Transitional Care services include, but are not limited to:

a. Developing strategies to reduce avoidable Member admissions and readmissions across all Members receiving ECM. Examples include establishing agreements and processes to ensure prompt notification to the Member's Lead Care Manager; planning timely scheduling of follow-up appointments with recommended outpatient Providers and/or community partners; developing policies to arrange transportation for transitional care, including to medical appointments, as per Non-Medical Transportation (NMT) and Non-Emergency Medical Transportation (NEMT) policy and procedures; and easing the Member's transition by addressing their understanding of rehabilitation activities, self-management activities and medication management.

b. For Members who are experiencing or are likely to experience a care transition:

   i. Developing and regularly updating a transition plan for the Member; this includes facilitating discharge instructions developed by a hospital discharge planner.

   ii. Evaluating a Member's medical care needs and coordinating any support services to facilitate safe and appropriate transitions from and among treatment facilities, including admissions and discharges.

   iii. Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.

   iv. Coordinating medication review/reconciliation.

   v. Providing adherence support and referral to appropriate services.

6) Member and Family Supports

Member and Family Supports include activities that ensure the ECM Member and family/support are knowledgeable about the Member's conditions, with the overall goal of improving their adherence to treatment and medication management. Member and Family Supports could include, but are not limited to:

a. Documenting a Member's authorized family member(s), guardian, AR, caregiver and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), AR, guardian, caregiver and/or authorized support person(s); and Contractor, as applicable.

b. Conducting activities to ensure the Member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

c. Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, AR, caregiver and/or other authorized support person(s).

d. Identifying supports needed for the Member and/or their family member(s), AR, guardian, caregiver and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services and assist them with making informed choices.

e. Providing for appropriate education of the Member and/or their family member(s), guardian, AR, caregiver and/or authorized support person(s) about care instructions for the Member.

f. Ensuring that the Member has a copy of his/her care plan and information about how to request updates.

7) Coordination of and Referral to Community and Social Support Services

Coordination of and Referral to Community and Social Support Services involves determining appropriate services to meet the needs of HHP Members receiving ECM, to ensure that any present or emerging social factors can be identified and properly addressed. Coordination of and Referral to Community and Social Support Services could include, but are not limited to:

a. Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as ILOS.

b. Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., “closed loop referrals”).

VI. Program Overlaps and Exclusions

ECM will coordinate all care for the highest-risk Members with complex medical and social needs, including across the physical and behavioral health delivery systems. Many Members who will be eligible for ECM may already be receiving some care management through other programs. In many of these instances, the ECM benefit will be additive, improve management of care across delivery systems, and comprehensively address any unmet medical and/or social needs. DHCS has determined three approaches for how ECM may overlap with existing programs that provide care management/care coordination services. Below is a summary of the programs that have been considered and the three potential approaches.

Figure 4: Summary of Approaches to ECM Overlaps/Non-duplication

1915 c Waivers	Services Carved Out of Managed Care Plans	Services Carved into Managed Care Plans	Duals	Other
Multipurpose Senior Services Program (MSSP)	California Children's Services (CCS)	CCS Whole Child Model	Dual Eligible Special Needs Plans (D-SNPs) [from 2023]	AIDS Healthcare Foundation Plans
Assisted Living Waiver (ALW)	Genetically Handicapped Person's Program (GHPP)	Basic Case Management	D-SNP look-alike plans	California Community Transitions (CCT) Money Follows the Person (MFTP)
Home and Community-Based Alternatives (HCBA) Waiver	County-based Targeted Case Management (TCM)	Complex Case Management	Other Medicare Advantage Plans	Mosaic Family Services
HIV/AIDS Waiver	Specialty Mental Health (SMHS) TCM	Community-Based Adult Services (CBAS)	Medicare FFS	Hospice
HCBS Waiver for Individuals with Developmental Disabilities (DD)	SMHS Intensive Care Coordination for children (ICC)		Cal MediConnect	
Self-Determination Program for Individuals with I/DD	Drug Medi-Cal Organized Delivery Systems (DMC-ODS)		Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs)	
			Program for All-Inclusive Care for the Elderly (PACE)	

1. ECM as a "wrap"	MCP Members can be enrolled in both ECM and the other program. ECM enhances and/or coordinates across the case/care management available in the other program. MCP must ensure non-duplication of services between ECM and the other program.
2. Either ECM or the other program	MCP Members can be enrolled in ECM or in the other program, not in both at the same time.
3. Excluded from ECM	Medi-Cal beneficiaries enrolled in the other program are excluded from ECM.

Ultimately, MCPs are responsible for ensuring non-duplication of services provided through ECM and any other program(s). As such, MCPs should regularly check available data feeds to evaluate which of their Members might be enrolled in other programs that provide care coordination. In addition, MCPs should establish processes and requirements to ensure ECM Providers ask Members about their participation in other programs as part of the in-person comprehensive assessment and care planning process.

The section below offers additional guidance about the relationship between ECM and the other programs listed in the diagram above.

ECM Interactions with Other Care Management Programs for Adults

1915(c) Waiver Programs

1915(c) Waiver Programs:
MCP Members can be enrolled in ECM or in a 1915(c) waiver program, not in both at the same time.

- 1915(c) waiver programs provide services to many Medi-Cal Members who will likely also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).
- There are comprehensive care management components within the 1915(c) waiver programs that are duplicative of ECM services.
- Members who are receiving 1915(c) services have a choice of continuing 1915(c) services or receiving ECM services.

Programs Carved Out of Managed Care

County-specified Targeted Case Management (TCM):[3]
MCP Members can be enrolled in ECM and county-specified TCM. ECM may enhance and/or coordinate across the case/care management available in county-specified TCM. ***The MCP must ensure non-duplication of services between ECM and county-specified TCM.***

- The TCM program is an optional Medi-Cal program funded by federal and local funds, serving approximately 30,000 Medi-Cal beneficiaries each year. **See Appendix C: Targeted Case Management** for which counties currently participate.
- The Centers for Medicare and Medicaid Services (CMS) requires that states require non-duplication between TCM and other care management approaches; however, CMS requirements do not prohibit Members from receiving both TCM and ECM at any given time, as long as the state ensures that services are not duplicated.
- MCPs are responsible for analyzing whether TCM is duplicative of ECM at the county program level and at the Member level.
    - ECM will act as a "wrap" on TCM **where TCM is not comprehensive** (e.g., in a county that offers specific homelessness interventions via TCM but without coordination of other health and social needs).

[3] County-specified TCM is distinct from TCM provided as a component of Specialty Mental Health Services (SMHS), which is covered below.

- If an MCP determines that the TCM **is comprehensive** and therefore substantially duplicative of ECM, the MCP must ensure that individuals do not receive both in that county.

- MCPs are expected to work with Local Governmental Agencies (LGAs) to ensure that Members receiving ECM services do not receive duplicative TCM services.
- Specifically, MCPs are required to demonstrate how they will prevent duplication in their respective Models of Care. The MOC Template requires MCPs to (a) list the TCM populations that LGAs are serving in each county they operate in, and (b) explain how the MCP will work with the county to ensure that Members do not receive duplicative services between ECM and TCM.

Specialty Mental Health Services (SMHS) Targeted Case Management (TCM):

MCP Members can be enrolled in ECM and SMHS TCM. ECM enhances and/or coordinates across the case/care management available in SMHS TCM. MCP must ensure non-duplication of services between ECM and SMHS TCM.

- DHCS administers the SMHS program, which is "carved out" of the broader Medi-Cal program under the authority of a 1915(b) waiver approved by CMS.
- The SMHS waiver program is administered locally by each county's Mental Health Plan (MHP), and each MHP provides, or arranges for, SMHS for Medi-Cal beneficiaries, including SMHS TCM and Full Service Partnerships (FSPs).
- MCP Members receiving SMHS TCM and FSP services from counties can also be eligible for and receive ECM services.
- MCPs are required to work with counties to identify Members receiving SMHS TCM or FSP services and ensure non-duplication of services.
- MCPs are required to prioritize contracting with county behavioral health Providers, as stated in the ECM and ILOS Contract Template Provisions: 3. ECM Providers.
- If an MCP Member receives services from a Specialty Mental Health Plan, and the Member's behavioral health Provider is a contracted ECM Provider, the MCP must assign that Member to the behavioral health Provider as the ECM Provider.

Drug Medi-Cal Organized Delivery Systems (DMC-ODS) and Drug Medi-Cal (DMC) Program:

MCP Members can be enrolled in ECM and the DMC-ODS/DMC Program. ECM enhances and/or coordinates across the case/care management available in the DMC-ODS/DMC Program. MCP must ensure non-duplication of services between ECM and the DMC-ODS/DMC Program.

- MCP Members participating in the DMC-ODS/DMC Program can also receive ECM services, so long as they also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).

- Given that many Members receiving services through the DMC-ODS/DMC Programs are also likely to be receiving SMHS TCM, MCPs are required to ensure non-duplication of services across all three programs.
- Please refer to Appendix C for an overview of counties participating in the DMC-ODS/DMC Programs.

Genetically Handicapped Person's Program (GHPP)

MCP Members can be enrolled in ECM and the GHPP. ECM enhances and/or coordinates across the case/care management available in the GHPP. MCP must ensure non-duplication of services between ECM and the GHPP.

- There are approximately 1,500 individuals enrolled in the GHPP program across the state; approximately 650 of them are also enrolled in Medi-Cal Managed Care.
- MCP Members participating in the GHPP can also receive ECM services, so long as they also meet the eligibility criteria for ECM (by belonging to at least one of the Populations of Focus).

Programs Carved into Managed Care

Basic and Complex Case Management:

MCP Members can be enrolled in ECM or in either Basic or Complex Case Management, not in both at the same time.

MCPs are required to offer Basic and Complex Case Management for Medi-Cal Managed Care Members. Please refer to Medi-Cal Managed Care Boilerplate Contract Exhibit A, Attachment 11, Provision 1. Comprehensive Care Management Including Coordination of Care Services.

Basic Case Management Services are provided by the Primary Care Provider, in collaboration with the MCP, and include:

- Initial Health Assessment (IHA);
- Individual Health Education Behavioral Assessment (IHEBA);
- Identification of appropriate Providers and facilities (such as medical, rehabilitation and support services) to meet Member care needs;
- Direct communication between the Provider and Member/family;
- Member and family education, including healthy lifestyle changes when warranted; and
- Coordination of carved-out and linked services, and referral to appropriate community resources and other agencies.

Complex Case Management Services are provided by the MCP, in collaboration with the Primary Care Provider, and include, at a minimum:

- The same services as covered by Basic Case Management;

- Management of acute or chronic illness, including emotional and social support issues, by a multidisciplinary case management team;
- Intense coordination of resources to ensure the Member regains optimal health or improved functionality;
- With Member and Primary Care Provider (PCP) input, development of care plans specific to individual needs, and updating of these plans at least annually;

MCP Members can only be enrolled in one case/care management approach at any given time. In addition, MCPs must assess the needs of their Members to determine which level of care management is most appropriate.

For Members transitioning from the WPC Pilots and HHP, the MCP must ensure that each Member is reassessed to determine the most appropriate level of care management or coordination of services. Basic or Complex Case Management may be alternatives to ECM that meet the needs of a Member who does not need the intensity of services offered by ECM.

Community-Based Adult Services (CBAS):

MCP Members can be enrolled in ECM and receive CBAS services. ECM enhances and/or coordinates across the case/care management available in CBAS centers. MCP must ensure non-duplication of services between ECM and CBAS centers.

- CBAS and ECM services are complementary.
- ECM can serve as a "wrap" and offer comprehensive care management beyond the services provided through CBAS, which are primarily provided within the four walls of the CBAS center.
- Given their connection to community resources, CBAS centers may also be well positioned to serve as ECM Providers.

Dual-Eligible Members

Dual-eligible Members enrolled in Cal MediConnect (CMC), Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) and Program for All-Inclusive Care for the Elderly (PACE) are excluded from ECM, on the basis that these plans offer comprehensive care management that is duplicative of ECM services.

However, all dual-eligible Members receiving HHP/WPC Pilot services will transition and be automatically authorized to receive ECM. ECM will also be available to dual-eligible Members if they meet ECM Populations of Focus criteria and are enrolled in an MCP. See Figure 5 below for an overview of which dual-eligible Members will be eligible to receive ECM. DHCS strongly encourages MCPs to offer ECM to dual-eligible Members, particularly when MCPs have information about which of their Members are receiving home and community-based services (HCBS). Additionally, many counties in California currently have D-SNPs, and some of those D-SNPs are operated by parent plans that also operate the MCP in the county. DHCS highly

encourages these MCPs to explore data sharing possibilities, and to work with the parent plans to coordinate care.

Figure 5: Overview of ECM Eligibility for Dual-Eligible Members in 2022

Medicaid & Medicare Delivery Model	ECM Eligible
Cal MediConnect	**No**
FIDE-SNPs	**No**
PACE Programs	**No**
Medi-Cal MCP + Medicare FFS	**Yes**
Medi-Cal MCP + Other MA	**Yes**
Medi-Cal MCP + D-SNP Look-alike	**Yes**
Medi-Cal MCP + D-SNP *(currently unaligned)*	**Yes**
Medi-Cal FFS + Medicare FFS or Plan *(not MCP enrolled)*	**No**

Separately from the implementation of ECM, CalAIM is focused on expanding access to integrated care for dual-eligible Members. This initiative includes mandatory enrollment for dual eligibles into MCPs for their Medi-Cal benefit and increasing the availability of aligned D-SNPs. Beginning in 2023 and by 2025, all MCPs will be required to operate D-SNPs, and will thus be responsible for benefits covered by both Medicare and Medi-Cal. Beginning in 2023, D-SNP Members who meet the ECM Populations of Focus criteria will be eligible for ECM. DHCS will release further information on coordination between ECM and D-SNPs by early 2022, ahead of the launch of aligned D-SNPs in 2023.

Other Programs

California Community Transitions (CCT) Money Follows the Person (MFTP)

MCP Members can be enrolled in ECM or in CCT MFTP, not in both at the same time.

Family Mosaic Project Services

Medi-Cal beneficiaries enrolled in Family Mosaic Project Services are excluded from ECM.

Hospice Recipients

MCP Members receiving hospice are excluded from ECM. The ECM benefit is fundamentally person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, members receive needed services in a supportive, effective, efficient, timely, and cost-effective manner. ECM emphasizes prevention, health promotion, continuity and coordination of care.

ECM Interactions with Other Care Management Programs for Children/Youth

California Children's Services (CCS) Classic,
CCS Whole Child Model (WCM)
Specialty Mental Health Services (SMHS) Intensive Care Coordination for children Children (ICC)

Guidance forthcoming.

VII. ECM Provider Network

Overview of ECM Providers
ECM will be delivered primarily by community-based ECM Providers that enter into contracts with MCPs. To provide Members with ongoing care coordination previously provided in HHP and WPC Pilot counties, MCPs are expected to contract with each WPC Lead Entity or HHP Community-Based Care Management Entity (CB-CME) as an ECM Provider unless there is an applicable exception. All contracting exceptions must be approved by DHCS in advance. DHCS also expects MCPs to work in close collaboration, and prioritize contracting with, county behavioral health systems, who often are the primary Providers of services to a subset of Medi-Cal beneficiaries.

ECM Providers may include, but are not limited to, the following entities:

- Counties;
- County behavioral health Providers;
- Primary Care Providers or Specialist or Physician groups;
- Federally Qualified Health Centers;
- Community Health Centers;
- CBOs;
- Hospitals or hospital-based Physician groups or clinics (including public hospitals and district and/or municipal public hospitals);
- Rural Health Clinics and/or
- Indian Health Service Programs;
- Local health departments;
- Behavioral health entities;

- Community mental health centers;
- SUD treatment Providers;
- Organizations serving individuals experiencing homelessness;
- Organizations serving justice-involved individuals;
- CCS Providers; and
- Other qualified Providers or entities that are not listed above, as approved by DHCS.

Requirements to Be an ECM Provider

ECM and ILOS Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those that will operate as ECM or ILOS Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many ECM and ILOS Providers (e.g., housing agencies, medically tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. These Providers must be vetted by the MCP in order to participate as ECM Providers, as described below.

Process for Medi-Cal Enrollment

For those ECM and ILOS Providers with a state-level Medi-Cal enrollment pathway, the process for enrolling would be identical to what happens today. The Provider would have to enroll through the DHCS Provider Enrollment Division, or the MCP can choose to have a separate enrollment process.

Clarifying Relationship with Provider "Credentialing" Requirements of APL 19-004

The credentialing requirements articulated in APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment only apply to Providers with a state-level pathway for Medi-Cal enrollment. ECM and ILOS Providers without a state-level pathway to Medi-Cal enrollment are **not** required to meet the credentialing requirements in APL 19-004 in order to become "in-network" ECM and/or ILOS Providers, but must be vetted by the MCP in order to participate. Furthermore, DHCS will not set licensing requirements for ECM care managers. MCPs should use and build on the processes they have already established for vetting the qualifications and experience of ECM Providers.

To include an ECM and ILOS Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be an ECM or ILOS Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and ILOS Providers in their submission of Part 2 of the MOC. MCPs must create and implement their own processes to do this. Criteria MCPs may want to consider as part of their process include, but are not limited to:

- Ability to receive referrals from MCPs for ECM or the authorized ILOS;
- Sufficient experience to provide services similar to ECM for Populations of Focus and/or the specific ILOS for which they are contracted to provide;
- Ability to submit claims or invoices for ECM or ILOS using standardized protocols;
- Business licensing that meets industry standards;

- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste and/or abuse;
- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

The same principles would apply to any ECM Provider or ILOS Provider for whom there is no state-level enrollment pathway.

ECM Provider Capacity
MCPs are required to contract with Providers that have experience serving the Populations of Focus, and that have expertise providing core ECM-like services. Because ECM will be a benefit, once an ECM Population of Focus is implemented in a county, MCPs must provide ECM to all eligible Members if they request it, and MCPs will be responsible for ensuring sufficient ECM Provider capacity to meet the needs of all ECM Populations of Focus in the counties in which they operate. However, DHCS recognizes that ECM Provider network development will take time, and expects MCPs to expand ECM network capacity over the first 12 months and on an ongoing basis, as well as for each Population of Focus.

MCPs will report on their ECM Provider capacity to DHCS initially in their MOC Template, and on an ongoing basis pursuant to DHCS reporting requirements. Additionally, MCPs are required to report 60 days in advance or as soon as possible on significant changes to ECM Provider capacity.

MCP Serving as ECM Provider
If an MCP is unable to provide sufficient capacity to meet the needs of all ECM Populations of Focus in a community-based manner through contracts with ECM Providers, they may request written approval for an exception to use their own staff to deliver ECM services. In these limited circumstances, MCP staff must also comply with all the requirements of being an ECM Provider (e.g., providing ECM services through in-person interactions and in the community). Any such request must be submitted in accordance with DHCS guidelines and must evidence one or more of the following:

- There are insufficient ECM Providers, or a lack of ECM Providers with experience and expertise to provide ECM for one or more of the Populations of Focus in one or more counties;
- There is a justified quality-of-care concern with one or more of the otherwise qualified ECM Providers;
- Contractor and the ECM Provider(s) are unable to agree on contracted rates;
- ECM Provider(s) is/are unwilling to contract;
- ECM Provider(s) is/are unresponsive to multiple attempts to contract;
- (For ECM Providers that have a state-level pathway to Medi-Cal enrollment) Provider(s) is/are unable to comply with the Medi-Cal enrollment process; or

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- (For ECM Providers without a state-level pathway to Medi-Cal enrollment) Provider(s) is/are unable to comply with Contractor's processes for vetting ECM Providers.

During any exception period approved by DHCS, the MCP must take steps to continually develop and increase the capacity of its ECM Provider Network. The initial exception period will be in effect no longer than one year. After the initial one-year period, the MCP must submit a new exception request to DHCS for DHCS review and approval on a case-by-case basis. Ultimately, these procedures have been established to align with the vision of providing ECM services through an in-person, community-based approach.

Experience Serving the ECM Populations of Focus:
ECM Providers may serve one or more of the Populations of Focus with which they have experience and expertise in serving, as well as the services they are proposing to provide to Members. ECM Providers do not have to have prior experience serving Medi-Cal MCP Members specifically. MCPs should determine what they deem as "sufficient experience" and describe it in their MOC.

Culturally Appropriate and Timely Care
ECM Providers must have the capacity to provide culturally appropriate and timely in-person care management activities. ECM Providers and Lead Care Managers must meet Members where they are in terms of the physical location that is most convenient and desirable for the Member to engage in services and from a medical management and plan of care perspective. ECM Providers must be able to communicate with Members in a culturally and linguistically appropriate and accessible way.

Formal Agreements with Other Entities
ECM Providers should also have formal agreements and processes in place to engage and cooperate with area hospitals, primary care practices, behavioral health Providers, Specialists and other entities, including ILOS Providers, to coordinate care as appropriate to each Member. MCPs have the discretion to determine which agreements are necessary or acceptable to meet this requirement, acknowledging that provider organizations will vary greatly in their capacity to share data outside their four walls.

Care Management Documentation System
ECM Providers must use a care management documentation system or process that supports the documentation and integration of physical, behavioral, social service and administrative data and information from other entities to support the management and maintenance of a Member care plan that can be shared with other Providers and organizations involved in each Member's care. Care management documentation systems may include Certified Electronic Health Record Technology, or other documentation tools that can: document Member goals and goal attainment status; develop and assign care team tasks; define and support Member care coordination and care management needs; gather information from other sources to identify Member needs and support care team coordination and communication; and support notifications regarding Member health status and transitions in care (e.g., discharges from a hospital or long-term care facility, housing status).

Transitioning HHP Model II and Model III
For MCPs that are transitioning their HHP to ECM and operate in alignment with either Model II or Model III, as described in the HHP Program Guide, DHCS expects that efforts will be made to shift those models to a more community-based Provider approach with less reliance on MCP staff in the provision of ECM. DHCS expects MCPs to submit a contract exception outlined in Section 4 of the Contract Template and will continue monitoring MCPs progress toward a community-based provider approach.

ECM Provider Payment
MCPs must pay contracted ECM Providers for the provision of ECM in accordance with contracts established between MCPs and each ECM Provider. MCPs must ensure that ECM Providers are eligible to receive payment when ECM is initiated for any given Member. MCPs are encouraged to tie ECM Provider payments to value, including payment strategies and arrangements that focus on achieving outcomes related to high-quality care and improved health status.

VIII. Engaging Members in ECM

Identifying Members for ECM
MCPs are responsible for regularly and proactively identifying Members who may benefit from ECM and who meet the criteria for the Populations of Focus. To do this effectively, MCPs must consider Members' health care utilization; needs across physical, behavioral, developmental and oral health; health risks and needs due to social determinants of health; and LTSS needs.

There are a number of potential data sources MCPs can leverage to identify Members for ECM, including but not limited to:

- Enrollment data;
- Encounter data;
- Utilization/claims data;
- Pharmacy data;
- Laboratory results data;
- Assessment data;
- Clinical information on physical and/or behavioral health;
- Health Information Form (HIF)/Member Evaluation Tool (MET) data;
- DHCS standardized "Staying Healthy" assessment tools or alternative Individual Health Education Behavioral Assessment (IHEBA) tools approved by DHCS and utilized by Primary Care Providers;
- Health Risk Stratification and Assessment survey for Seniors and Persons with Disabilities (SPD);

- SMI/SUD data, as available;
- Risk stratification information for children in County Organized Health System (COHS) counties with Whole Child Model programs;
- Information about social determinants of health, including standardized assessment tools and/or ICD-10 codes;
- Results from any available Adverse Childhood Experience (ACE) screening; and
- Other cross-sector data and information, including housing, social services, foster care, criminal justice history and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system).

MCPs will need to rely on a combination of information provided by DHCS on a regular basis and data internal to the plan. DHCS provides encounter data including physical and behavioral health utilization, to MCPs monthly in a standard file format. For example, to identify Members who are high utilizers, MCPs could rely on the frequency of utilization reflected in the data feeds from DHCS. Whenever feasible, MCPs should also consider any data or relevant characteristics provided as part of data exchanged between the MCP and Provider organizations.

Another important avenue for Member identification is through referrals. MCPs are contractually obligated to inform Members and their families, guardians and caregivers, ECM Providers, ILOS Providers, other Providers, and CBOs, about ECM, the ECM Populations of Focus, and how to request ECM. MCPs must consider requests for ECM from Members and on behalf of Members from all of the entities described above. It is expected that MCPs will establish strong referral relationships with ECM Providers and other CBOs, including developing a process for receiving and responding to referral requests from ECM Providers and other entities. For example, shelters, homeless services Providers, recuperative care Providers and other service Providers will be better positioned to identify individuals and families experiencing homelessness. Similarly, county behavioral health plans will be well-positioned to refer Adults with SMI and SUD who may benefit from ECM.

Authorizing ECM for MCP Members
MCPs and/or their subcontractors or contracted Providers will evaluate Member eligibility for ECM and authorize individuals for ECM. MCPs are responsible for developing Policies and Procedures that explain how they will verify eligibility and authorize ECM for eligible Members in an equitable and non-discriminatory manner without disrupting their care.

For requests from Providers, other external entities, Members or family:

- MCP must ensure that authorization or a decision not to authorize ECM occurs as soon as possible (i.e., within five working days for routine authorizations and within 72 hours for expedited requests), in accordance with Exhibit A, Attachment 5, Provision 3, Timeframes for Medical Authorization and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and “Your Rights” Attachments.

- If MCP does not authorize ECM, Contractor must ensure the Member and the requesting individual or entity (as applicable) who requested ECM on a Member's behalf are informed of the Member's right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeal System, and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
- For Members who were not authorized to receive ECM, Contractor must follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System, and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.
- To inform Members that ECM has been authorized, Contractor must follow its standard notice process outlined in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

MCPs are encouraged to work with ECM Providers to define a process and appropriate circumstances for presumptive authorization or preauthorization of ECM, whereby select ECM Providers would be able to directly authorize ECM and be paid for ECM services for a fixed period of time until Contractor authorizes or denies ECM based on a complete assessment of Member eligibility for ECM consistent with Population of Focus criteria. There may be a subset of high-performing Providers with the MCPs' contracted Network of Providers for whom this capability would make sense.

Assignment to an ECM Provider
MCPs will assign every Member authorized for ECM to an ECM Provider. Note that some Members authorized to receive ECM may meet the criteria for multiple Populations of Focus. MCPs will assign these individuals to an ECM Provider that has appropriate competencies and experience for the needs of the Member. For example, individuals with SUD may also be people experiencing homelessness. These Members may be assigned to an ECM Provider that has the necessary skills and experience to work with SUD and homeless populations.

MCPs will develop a process to disseminate information about assigned Members to ECM Provider(s) on a regular cycle, and will ensure that communication of Member assignment to the designated ECM Provider occurs within ten (10) business days of authorization. MCPs are also required to document the Member's ECM Lead Care Manager, who will serve as the point of contact for the Member, in its system of record.

Listed below are additional guidelines for the ECM Provider assignment process.

Member Preference
If Member preference for a specific ECM Provider is known to the MCP, the MCP must honor that preference when assigning the ECM Provider, to the extent practicable. Further, MCPs must permit Members to change ECM Providers at any time and are expected to implement any

requested ECM Provider change within 30 days to the extent the requested ECM Provider is able to accommodate the change.

Member Primary Care Provider (PCP)
If the Member's assigned PCP is a contracted ECM Provider, the MCP must assign the Member to the PCP as the ECM Provider, unless the Member has expressed a different preference or MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions. The MCP must notify the Member's PCP, if different from the ECM Provider, of the assignment to the ECM Provider, within ten (10) business days of the date of assignment.

Member Behavioral Health Provider
If a Member receives services from a Specialty Mental Health Plan for SUD and/or SMI, and the Member's Behavioral Health Provider is a contracted ECM Provider, the MCP must assign that Member to that Behavioral Health Provider as the ECM Provider, unless the Member has expressed a different preference or the MCP identifies a more appropriate ECM Provider given the Member's individual needs and health conditions.

Initiating Delivery of ECM

Member Consent
MCPs must not require ECM Providers or their own staff to obtain Member consent to participate (in writing or otherwise) as a condition of initiating delivery of ECM, unless required by federal law. DHCS removed documentation requirements to streamline and simplify implementation of the benefit. However, an individual may decline to engage in or continue ECM at any time.

Written Authorization for ECM-related Data Sharing
MCPs are not required to obtain Member authorization (in writing or otherwise) for data sharing as a condition of initiating delivery of ECM, unless such authorization is required by federal law. MCPs must develop Policies and Procedures with their Network of ECM Providers to:

- Where required by federal law, ensure that Members authorize information sharing with the Contractor and all others involved in the ECM Member's care as needed to support the Member and maximize the benefits of ECM.
- Communicate Member-level record of written authorization to allow data sharing (once obtained) back to the MCP.

Dedicated Lead Care Manager
MCPs are required to ensure that each Member receiving ECM has a dedicated Lead Care Manager with responsibility for interacting directly with the Member and/or family, Authorized Representatives (ARs), caretakers, and/or other authorized support person(s), as appropriate. The assigned Lead Care Manager is responsible for engaging with a multi-disciplinary care team to identify gaps in the Member's care and ensure appropriate input is obtained to effectively coordinate all primary, behavioral, developmental, oral health, LTSS, ILOS and other services that address social determinants of health (SDOS), regardless of setting, at a minimum. DHCS is not providing required staffing ratios for the number of Members who can be served by each care manager at this time.

Member-level Records
MCPs are required to ensure that accurate and up-to-date Member-level records related to the provision of ECM services are maintained for Members authorized for ECM.

Discontinuing Delivery of ECM
Circumstances for Discontinuing ECM
Members are able to decline or end ECM upon initial outreach and engagement, or at any other time. ECM Providers will be required to notify MCPs to discontinue ECM for Members when any of the following circumstances are met:

- The Member has met all care plan goals;
- The Member is ready to transition to a lower level of care;
- The Member no longer wishes to receive ECM or is unresponsive or unwilling to engage (this can include instances when a Member's behavior or environment is unsafe for the ECM Provider); or
- The ECM Provider has not been able to connect with the Member after multiple attempts.

Notice of Action (NOA) Process
MCPs are required to develop processes to determine discontinuation of ECM and notify ECM Providers to initiate discontinuation of services in accordance with the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

MCPs must notify the Member of the discontinuation of the ECM benefit and ensure the Member is informed of their right to appeal and the appeals process by way of the Notice of Action (NOA) process as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals, and APL 17-006: Grievance and Appeal Requirements and Revised Notice Templates and "Your Rights" Attachments.

Transitioning Members from ECM
MCPs must develop processes for transitioning Members from ECM to lower levels of care management to provide coordination of ongoing needs.

IX. Data System Requirements & Data Sharing to Support ECM

The vision of ECM is to embrace and integrate a greater diversity of non-traditional Providers in the delivery of whole-person care. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this vision from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and ECM Providers.

DHCS is developing more comprehensive guidance that will describe the minimum set of data elements required to be included in an invoice, along with ECM Member Assignment File and Encounter History File reporting standards, to be finalized by September 2021.

Data System Requirements
MCPs are required to have an IT infrastructure and data analytic capabilities to support ECM, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in ECM Contract Template Section 7: Identifying Members for ECM, to identify Populations of Focus;
- Assign Members to ECM Providers;
- Keep records of Members receiving ECM and authorizations necessary for sharing Personally Identifiable Information between Contractor and ECM and other Providers, among ECM Providers and family member(s) and/or support person(s), whether obtained by ECM Provider or by Contractor;
- Securely share data with ECM Providers and other Providers in support of ECM;
- Receive, process and send encounters and invoices from ECM Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from ECM Providers;
- Send ECM supplemental reports to DHCS; and
- Open, track and manage referrals to ILOS Providers.

Data Sharing Requirements for MCPs
In order to support ECM, MCPs shall provide, at a minimum, the following information to all ECM Providers:

- Member assignment files, which include a listing of Medi-Cal Members authorized for ECM and assigned to the ECM Provider;
- Historical encounters/claims data for assigned Members;
- Physical, behavioral and administrative information, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS)[4] for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and state standards, specifications, code sets and terminologies when sharing physical, behavioral, social and administrative data with ECM Providers and with DHCS.

Data Sharing Requirements for ECM Providers
DHCS' vision is that ECM Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs.

DHCS is not specifying the payment model between MCPs and Providers for ECM, though DHCS encourages plans and Providers to adopt or progress to value-based payment models for ECM. Regardless of payment model or reimbursement modality, MCPs are expected to collect encounters from Providers for submission to DHCS.

ECM Providers and MCPs may need to reconfigure their existing systems to meet these requirements.

X. Oversight of ECM Providers

MCP Requirements
MCPs are required to perform oversight of ECM Providers, holding them accountable to all ECM requirements contained in the ECM and ILOS Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use ECM Provider Standard Terms and Conditions (STCs) to develop ECM contracts with ECM Providers, and are expected to incorporate all ECM Provider requirements reviewed and approved by DHCS as part of their MOC, including all monitoring and reporting criteria. To streamline the ECM implementation:

- MCPs must hold ECM Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.
- MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting.
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of ECM Providers.

NCQA Accreditation Requirements
In order to maximize ECM and ILOS Provider networks and ease provider burden, the ECM ILOS Contract Section 3.h specifies that the MCP *" shall not require eligible ECM Providers to be National Committee for Quality Assurance (NCQA) certified or accredited as a condition of contracting as an ECM Provider."* Additionally, MCPs must not utilize tools developed or promulgated by NCQA to perform oversight of ECM Providers, unless by mutual consent with the ECM Provider.

All MCPs must be NCQA accredited by 2026. DHCS understands that MCPs may need to meet NCQA requirements as they pertain to their delivery of Complex Case Management (CCM) and that it can be helpful to NCQA and the MCPs if the state clarifies its position in formal guidance.

The below framework and core principles may be used by MCPs in their efforts on meeting NCQA accreditation.

1. A Managed Care Plan (MCP) may, or may not, choose to integrate the CCM program with ECM by delegating CCM functions to community-based ECM Providers. The MCP may decide to retain the CCM functions as MCP-operated functions, and keep the ECM functions separate and distinct.
2. If the MCP decides to retain the CCM functions, rather than delegating them to community-based ECM Providers, then CCM would not be considered to be delegated, and no CCM pre-delegation review activities would be required for community-based ECM Providers.
3. However, if the MCP decides to delegate CCM functions to ECM Providers, then these ECM Providers would be subject to CCM pre-delegation review requirements.
4. If the MCP delegates CCM, then the pre-delegation review would be the responsibility of the MCP. States may take on this responsibility in other parts of the country, but California will not do this.

DHCS continues to finalize guidance for ECM as it relates to NCQA and will make updates to the ECM Policy Guide as necessary.

Training
As previously stated, MCPs must notify all Providers in their network about ECM and ILOS to enable appropriate referrals of their Members. MCPs must also provide ECM training and technical assistance to ECM Providers, including in-person sessions, webinars and/or calls, as necessary, in addition to Network Provider training requirements described in Medi-Cal Boilerplate Template, Exhibit A, Attachment 7, Provision 5, Network Provider Training.[5]

Subcontracting Agreements

MCPs may subcontract with other entities to administer ECM, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS-approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's ECM Provider capacity is sufficient to serve all Populations of Focus;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or counties in which Members are served; and

[5] DHCS MMCD Boilerplate Contracts Template.

- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation.

It is well understood by DHCS that primary plans and Subcontractors have different Provider networks. However, DHCS will hold the primary MCP accountable for the requirements of ECM and ILOS. DHCS will assess the combined network of the primary MCP and Subcontractors for sufficiency and will hold the primary MCP responsible.

MCPs may also choose to delegate ECM to Independent Physician/Provider Associations (IPAs), Medical Groups and Management Service Organizations (MSOs). MCPs must describe these arrangements in the MOC for DHCS approval. IPAs and MSOs must meet all requirements.

MCPs will ensure their Subcontractor agreements for ECM and ILOS services include the requirements set forth in the ECM and ILOS Contract Template, and the ECM Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to ECM to minimize variance in how ECM will be implemented and to ensure a streamlined, seamless experience for ECM Providers and Members.

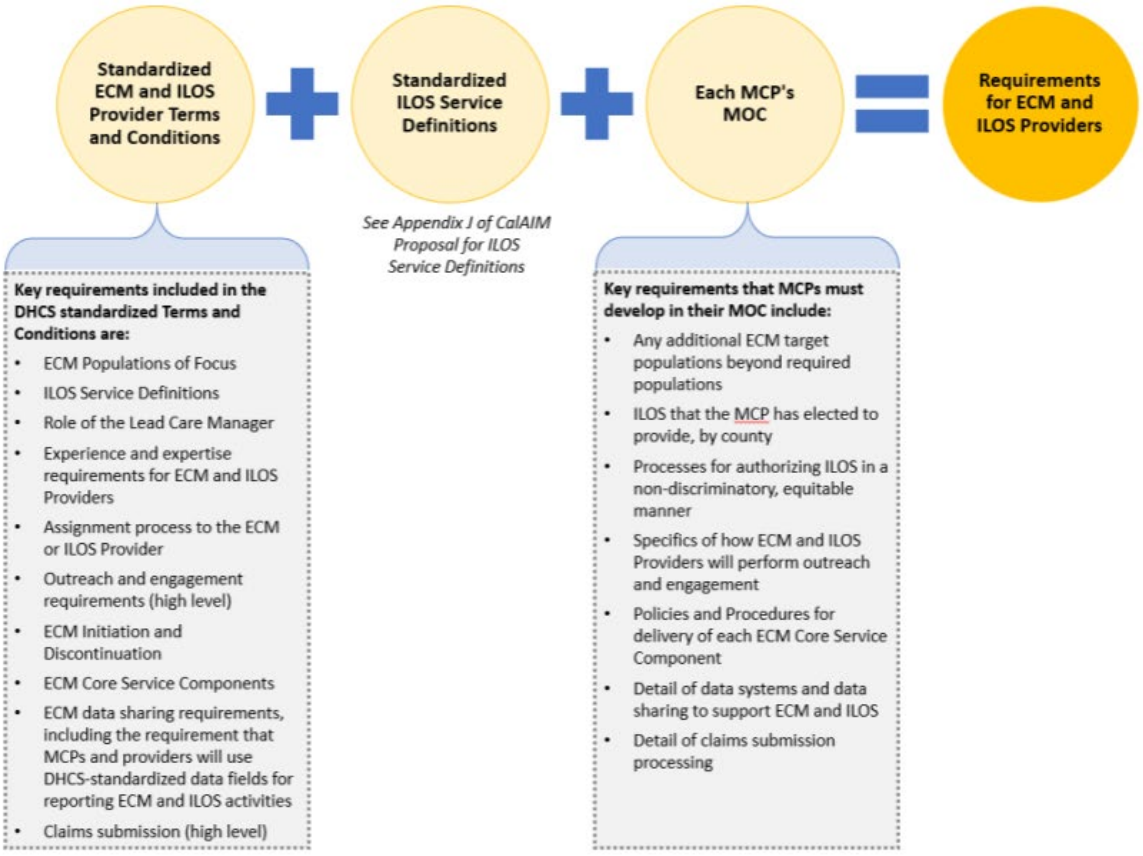
XI. DHCS Oversight of ECM

Model of Care (MOC) and Approval Process
The ECM and ILOS MOC is each MCP's framework for providing ECM and ILOS. Each MCP's MOC will include its overall approach to ECM and ILOS; its detailed Policies and Procedures with regard to ECM and ILOS Provider (including non-traditional Providers) contracting and oversight; its ECM and ILOS Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and ILOS Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in WPC and/or HHP counties. MCPs in these counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and ILOS.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and ILOS requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and ILOS implementation as well as for counties without HHP or WPC.. MCPs must make updates to their MOCs (1) ahead of new ECM Populations of Focus being implemented in January and July 2023 and (2) to reflect any ILOS changes, based on the Timelines for MOC Submission in the ECM and ILOS Model of Care Cover Note. MCPs must also submit to DHCS any significant changes to its MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable DHCS APLs. Significant changes may include, but are not limited to, changes to the Contractor's s approach to administer or deliver ECM services, approved policies and procedures, and Subcontractor Agreements boilerplates.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Figure 6: Elements of ECM and ILOS Provider Requirements



Encounter Data

DHCS will review encounter data submitted by MCPs to monitor the overall reach of ECM. MCPs must submit all ECM encounters to DHCS using national standard specifications and code sets defined by DHCS. MCPs will be responsible for submitting all encounter data for ECM services provided to its Members, regardless of the number of levels of delegation and/or sub-delegation. As mentioned above in Data System and Data Sharing Requirements to Support ECM, in the event the ECM Provider is unable to submit ECM encounters using the national standard specifications and code sets defined by DHCS, the MCP will be responsible for converting the ECM Provider's encounter information into the national standard specifications and code sets, for submission to DHCS. DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates.

Quarterly Implementation Reporting Requirements
DHCS will monitor Medi-Cal Managed Care health plans' (MCPs') implementation of and compliance with Enhanced Care Management (ECM) and In Lieu of Services (ILOS) requirements across multiple domains, including Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor the impact of ECM and ILOS through a combination of data sources, including Member-level data reported by MCPs and as demographic data currently available to DHCS. The data supplied by MCPs will serve as a mechanism for DHCS to monitor the initial rollout of ECM and will be used in the implementation of performance incentives. Some of the monitoring data will be used for the implementation of MCP Performance Incentives, as described further below.

Requirement to Track Outreach to Inform ECM Rate Development
The MCP contract specifies that *"Contractor shall track and report to DHCS, in a format to be defined by DHCS, information about outreach efforts related to potential Members to be enrolled in ECM".* As a component of the rate setting process, MCPs must maintain internal tracking of outreach efforts related to potential ECM enrollees, prior to the Member's actual enrollment in ECM.

Please note, this information will be requested by way of a Supplemental Data Request (SDR) process and the initial request will likely occur within the first 12 months after initial implementation and on an ad hoc basis thereafter. Although this information is expected to be tracked with the ability to report accurately at quarterly intervals, there is not a requirement to submit this data to DHCS on a quarterly cadence.

At a quarterly interval, MCPs are expected to track at a minimum:

- Number of identified individuals targeted for ECM;
- Number of individuals targeted for ECM with at least one outreach attempt (an outreach attempt is defined as using an in-person, telephonic or an individualized electronic communication method to connect with an individual, unduplicated);
- Number of total outreach attempts (by attempt method);
- Number of successful outreach attempts (a successful attempt is defined as an actual interaction with the individual); and
- Total time spent (in hours) performing outreach efforts related to potential ECM enrollees.

DHCS may modify or add to the above list, with prior notice to MCPs of such changes, and MCPs would be expected to comply with the updated tracking requirements on a prospective basis.

MCPs will submit ECM outreach tracking reports to DHCS upon request by way of the SDR process for rate setting purposes.

ECM Provider Reporting in 274
In order to monitor ECM and ILOS Providers on an ongoing basis, DHCS will require MCPs to report ECM Providers in the 274 Provider file, beginning upon implementation. Guidance related to reporting ECM Providers in the 274 Provider file is forthcoming.

XII. Performance Incentive Program

Overview:
CalAIM's ECM and ILOS programs will require significant new investments in care management capabilities, ILOS infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and Provider levels. Incentive payments will be a critical component of CalAIM to promote MCP and Provider participation in, and capacity building for, ECM and ILOS.

The Governor's budget allocated $300 million for plan incentives from January to June 2022, $600 million from July 2022 to June 2023, and $600 million from July 2023 to June 2024. Incentive funding will phase out in FY 2024-25. DHCS has designed an incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022, for the achievement of defined milestones. Infrastructure development, ECM and ILOS Provider capacity building, and ILOS take-up are priority areas for Program Year 1 (i.e., Calendar Year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., Calendar Year 2023).

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and ILOS capacity.
- Drive MCP investment in necessary delivery system infrastructure.
- Incentivize MCP take-up of ILOS.
- Bridge current silos across physical and behavioral health delivery.
- Reduce health disparities and promote health equity.
- Achieve improvements in quality performance.

Performance Incentive Design Principles:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably.
2. Set ambitious, yet achievable measure targets.
3. Ensure efficient and effective use of all performance incentive dollars.
4. Drive significant investments in core priority areas up front.
5. Minimize administrative complexity.
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC)/Health Home Program (HHP) counties and non-WPC/HHP counties.
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates.
8. Measure and report on the impact of incentive funds.

XIIII. Appendices

Appendix A: ECM Implementation Dates by County

Counties with WPC Pilots and/or HHP[6] (Begin ECM implementation on 1/1/22)		Counties without WPC Pilots and/or HHP (Begin ECM implementation on 7/1/22)
Alameda	HHP, WPC	Alpine
Contra Costa	WPC	Amador
Imperial	HHP	Butte
Kern	HHP, WPC	Calaveras
Kings	WPC	Colusa
Los Angeles	HHP, WPC	Del Norte
Marin	WPC	El Dorado
Mendocino	WPC	Fresno
Monterey	WPC	Glenn
Napa	WPC	Humboldt
Orange	HHP, WPC	Inyo
Placer	WPC	Lake
Riverside	HHP, WPC	Lassen
Sacramento	HHP, WPC	Madera
San Bernardino	HHP, WPC	Mariposa
San Diego	HHP, WPC	Merced
San Francisco	HHP, WPC	Modoc
San Joaquin	WPC	Mono
San Mateo	WPC	Nevada
Santa Clara	HHP, WPC	Plumas
Santa Cruz	WPC	San Benito
Shasta	WPC	San Luis Obispo
Sonoma	WPC	Santa Barbara
Tulare	HHP	Sierra
Ventura	WPC	Siskiyou
		Solano
		Stanislaus
		Sutter
		Tehama
		Trinity
		Tuolumne

[6] List is subject to change based on WPC Pilots' decisions to continue operating through 2021.

Counties with WPC Pilots and/or HHP[6] (Begin ECM implementation on 1/1/22)	Counties without WPC Pilots and/or HHP (Begin ECM implementation on 7/1/22)
	Yolo Yuba

Appendix B: ECM Populations of Focus: Additional Guidance & Examples of ECM Services

Population of Focus #1:
Individuals and Families Experiencing Homelessness

Individuals who:

(1) are experiencing homelessness (as defined below)

AND

(2) have at least one complex physical, behavioral or developmental health need with inability to successfully self-manage, for whom coordination of services would likely result in improved health outcomes **and/or** decreased utilization of high-cost services.

Additional Guidance & Examples of ECM Services:
Individuals experiencing homelessness are among the highest-need individuals in Medi-Cal. They often lack access to necessities such as food and shelter that are critical to attaining health. These individuals often have extensive medical and behavioral health needs that are difficult to manage due to the social factors that influence their health. This often results in high utilization of costly services such as emergency departments and inpatient settings.

Engagement for this population may include street outreach or coordinating with shelters, Homeless Services Providers, Recuperative Care Providers, Community Partners (e.g., Homeless Coordinated Entry Systems) and other service Providers.[7] As individuals are connected to resources, the ECM Lead Care Manager will meet the Member in the community or at Provider locations.

ECM can be used to link individuals with a variety of services to meet their complex needs. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Utilizing housing-related in lieu of services (ILOS) to identify housing and preparing individuals to secure and/or maintain stable housing.
- Coordinating short-term post-hospitalization housing and recuperative care services as appropriate.
- Maintaining regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs, and swiftly

[7] These same entities will be important referral partners to identify potential enhanced care management candidates.

addressing those gaps to ensure progress toward regaining health and function continues.

- Coordinating and collaborating with various health and social services Providers, including Regional Centers, including sharing data (as appropriate) to facilitate better-coordinated whole-person care.
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Addressing barriers to housing stability by connecting Members and their families to housing, health and social support resources.
- Utilizing best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions, including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing and Trauma Informed Care.

Population of Focus #2:
Adult High Utilizers

Adults with:
(1) **five or more** emergency room visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence;

AND/OR

(2) **three or more** unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

MCPs may also authorize ECM for other individuals with a pattern of very high utilization that could have been avoided with appropriate care or improved treatment adherence.

Additional Guidance and Examples of ECM Services:
MCPs should use standard methods to identify Members who are high utilizers and clarify their methods in their Policies and Procedures. It is very likely that adult high utilizers will also meet the criteria for multiple Populations of Focus. Thus, the services provided to these Members will likely represent a mix of services from the examples provided across the Populations of Focus, in addition to the Core Service Components.

Population of Focus #3:
Adult SMI/SUD

Adults who:
(1) **meet the eligibility criteria** for participation in or obtaining services through:
- The county Specialty Mental Health (SMH) System **AND/OR**
- The Drug Medi-Cal Organization Delivery System (DMC-ODS) **OR** the Drug Medi-Cal (DMC) program.

AND
(2) are actively experiencing at least one complex social factor influencing their health (e.g., lack of access to food, lack of access to stable housing, inability to work or engage in the community, history of ACEs, former foster youth, history of recent contacts with law enforcement related to mental health and/or substance use symptoms or associated behaviors);
AND
(3) **meet one or more of the following criteria:**
- Are at high risk for institutionalization, overdose and/or suicide;
- Use crisis services, emergency rooms, urgent care or inpatient stays as the sole source of care;
- Experienced two or more ED visits or two or more hospitalizations due to SMI or SUD in the past 12 months;
- Are pregnant or post-partum women (12 months from delivery).

Additional Guidance and Examples of ECM Services:
Initial engagement for adults with SMI/SUD may occur in treatment settings such as psychiatric inpatient units, Institutions for Mental Diseases (IMDs) or residential settings. However, ECM Providers are expected to coordinate across all the delivery systems through which Members need to access care. Further, as detailed in Section V. Program Overlaps and Exclusions, MCPs are responsible for ensuring non-duplication of services across delivery systems. Given that adults with SMI/SUD might also be receiving services through Specialty Mental Health Plans (SMHPs) and/or the Drug Medi-Cal Organized Delivery Systems (DMC-ODS) or Drug Medi-Cal Program (DMC), it is especially important for MCPs to coordinate with county behavioral health staff. As such, MCPs should prioritize contracting with county behavioral health staff to serve as ECM Providers, provided they agree and are able to coordinate all services needed by the Member, not just behavioral health services. When MCPs are not able to contract with county behavioral health staff as the ECM Provider, ECM Providers for this population should have experience and expertise working with individuals with SMI and SUD, as well as the ability to adequately coordinate services across multiple delivery systems. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Providing post-hospitalization or post-residential medical treatment care planning to connect individuals with the supports they need to avoid rehospitalization, including identifying culturally and linguistically appropriate community placements. These services should be provided in close coordination with county behavioral health plans when the

hospitalization or residential treatment occurs due to mental illness or substance use disorder.

- Facilitating regular culturally and linguistically appropriate contact with Members to ensure there are not gaps in the activities designed to avoid institutionalization or hospitalization and swiftly addressing those gaps to ensure the individual can remain in the community placement.
- Utilizing housing-related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing, if needed, and connecting to other social services to address social factors that influence the individual's health outcomes.
- Supporting the Members' behavioral health recovery goals with related improvements in physical and oral health and long-term services and supports.
- Connecting families, caretakers and circles of support to resources regarding the Member's conditions to assist them with providing support for the Member's health/behavioral health.
- Coordinating and collaborating with various health, behavioral health, developmental disability and social services Providers, including sharing data (as appropriate).
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.

Population of Focus #4:
Individuals Transitioning from Incarceration

Individuals who:
(1) are transitioning from incarceration or transitioned from incarceration within the past 12 months

AND

(2) have at least one of the following conditions:
- Chronic mental illness
- Substance Use Disorder (SUD)
- Chronic disease (e.g., hepatitis C, diabetes)
- Intellectual or developmental disability
- Traumatic brain injury
- HIV
- Pregnancy

Additional Guidance and Examples of ECM Services:
Some Members transitioning from incarceration have significant health and behavioral health care needs that require ongoing treatment in the community post-release. These Members often also experience significant social factors that impact their ability to successfully manage their health, such as lack of safe and stable housing and unemployment. Upon transition back to the community, individuals are required to coordinate a significant number of basic life needs and, as a result, often experience care disruptions, which result in deterioration of their conditions and increased use of emergency departments and inpatient settings. For some individuals, unmet health care needs can increase their likelihood of returning to incarceration; diversion programs are designed to address these needs and avoid incarceration.

For this Population of Focus, ECM requires coordination with the state prison system and local corrections departments, including probation, courts and the local county jail system, both to identify/refer Members and also to ensure connections to care once individuals are released from incarceration. Upon release, all individuals receiving ongoing behavioral health treatment (including treatment for SUD) should be referred to county behavioral health programs and MCPs on an as-needed basis. MCPs and county behavioral health programs should coordinate closely to better serve clients that receive services from both entities.

The initial ECM engagement locations will depend on the collaborations that MCPs are able to build with local justice partners. At first, ECM Lead Care Managers will begin working with individuals expected to transition from incarceration in the setting where they are incarcerated (or just outside that setting), or in criminogenic treatment programs.[8] Post-transition, ECM Lead Care Managers will engage individuals in the most easily accessible setting for the Member. In addition

[8] DHCS is looking to leverage H.R. 6 SUPPORT Act to begin providing ECM for individuals exiting from incarceration with known medical and behavioral health needs 30 days prior to release. ECM dollars will not be able to be used to provide services directly to justice-involved Members prior to release.

to community-based engagement such as a Member's home or regular Provider office, this may also include parole or probation offices if the MCP builds partnerships that allow for engagement in those settings.

ECM can be used to link individuals transitioning from incarceration (or in diversion programs) with a variety of services to meet their complex needs. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Coordinating an initial risk assessment to evaluate medical, psychiatric, substance use and social needs for which the individual requires assistance.
- Establishing direct connections with community Providers to ensure continuity of care for their conditions (especially for medications) and to address any health care needs not treated while they were incarcerated. This will also include peer mentorship to help provide positive social support.
- Utilizing housing-related ILOS to identify housing and prepare individuals for securing and/or maintaining stable housing.
- Ensuring regular contact with Members to safeguard against gaps in the activities designed to address an individual's health and social service needs, and swiftly address those gaps to prevent reincarceration and ensure progress toward regaining health and function continues.
- Screening and providing referrals for various health, developmental disabilities, mental health, substance use disorder and social service needs.
- Coordinating and collaborating with various health, behavioral health and social services Providers as well as parole/probation, including sharing data (as appropriate) to facilitate better-coordinated, whole-person care.
- Supporting Member treatment adherence, including scheduling appointments, appointment reminders, coordinating transportation, ensuring connection to public benefits, identifying barriers to adherence and accompanying Members to appointments, as needed.
- Helping Members set and monitor health goals to maintain or improve their health.
- Providing culturally and linguistically appropriate education to families, caretakers and circles of support regarding the Member's health care needs and available supports.
- Navigating Members to other reentry support Providers to address unmet needs.
- Facilitating benefits reinstatement.[9]

[9] To complement these efforts, DHCS is proposing to mandate that all counties implement a county inmate pre-release Medi-Cal application process by January 1, 2023. The ECM Lead Care Manager would also help facilitate accessing other benefits as needed by the Member.

Population of Focus #5:
Individuals at Risk for Institutionalization and Eligible for Long-Term Care Services

Individuals at risk for institutionalization who are eligible for Long-Term Care services who, in the absence of services and supports, would otherwise require care for 90 consecutive days or more in an inpatient nursing facility (NF). Individuals must be able to live safely in the community with wraparound supports.

Additional Guidance and Examples of ECM Services: Services for this Population of Focus are focused on preventing skilled nursing admissions for individuals with an imminent need for nursing facility placement. In addition to the Core Service Components, examples of applicable services for this Population of Focus include (but are not limited to):

- Performing an assessment to determine natural supports available, risk factors, social determinants of health and other factors to determine safety and feasibility of continued stay in the community. Assessments should be conducted face-to-face whenever possible.
- Connecting to needed supportive services, including ILOS such as meals, environmental accessibility adaptations (home modifications) and personal care.
- Maintaining frequent follow-up visits (including regular home visits).
- Providing culturally and linguistically appropriate education and care coordination activities to ensure the Member and family/caregiver needs are being met where they are.
- Connecting to appropriate culturally and linguistically aligned CBOs, programs and resources that will meet the Member's needs.
- Ensuring placement of wraparound services to maintain the Member in their current, community setting.
- Facilitating Member treatment adherence, including scheduling appointments, appointment reminders, ensuring connection to public benefits, coordinating transportation, identifying barriers to adherence and accompanying Members to appointments, as needed.

Population of Focus #6:
Nursing Facility Residents Who Want to Transition to the Community

Nursing facility residents who are strong candidates for successful transition back to the community and have a desire to do so.

Additional Guidance and Examples of ECM Services:
Members of this Population of Focus must have an identified support network system and housing available to them. The support network system may consist of care Providers, community-based organizations, family members, primary care physicians, home health agencies, members of the individual's medical team, licensed foster parents or any other individual who is part of the Member's circle of support. The individual's support network may consist of family members, a legal representative/legally responsible adult and any other person named by the individual. The care team will help individuals move safely between different care settings, such as entering or leaving a hospital or nursing facility and returning to their own home.

In addition to the Core Service Components, services include facilitating nursing facility transition back into a homelike and community setting with the necessary wraparound services, community supports and natural supports, when available.

ECM Lead Care Manager visits will occur in person at the facility throughout the transition process. An in-person home visit will occur prior to the individual's move to ensure the health and safety of the new residence. Post-transition individuals will then be visited in person at a determined schedule at their home or community placement.

Appendix C: Local Governmental Agencies Participating in the County-specified Targeted Case Management Program

Note: The table below reflects information as of March 2021. For the most accurate information, MCPs should check directly with the counties.

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Alameda County	X	X	X	X	X	
Alpine County						X
Amador County						X
Butte County				X		
Calaveras County						X
Colusa County						X
Contra Costa County	X	X	X	X	X	
Del Norte County						X
El Dorado County						X
Fresno County						X
Glenn County						X
Humboldt County	X	X		X	X	
Imperial County						X
Inyo County						X
Kern County	X			X		
Kings County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalization	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Lake County						X
Lassen County						X
Los Angeles County	X			X		
Madera County				X		
Marin County						X
Mariposa County	X	X	X	X	X	
Mendocino County						X
Merced County				X		
Modoc County						X
Mono County						X
Monterey County	X	X		X		
Napa County	X	X		X		
Nevada County						X
Orange County	X			X	X	
Placer County		X	X	X		
Plumas County						X
Riverside County	X	X	X	X	X	
Sacramento County	X			X		
San Benito County						X
San Bernardino County						X
San Diego County	X	X	X	X	X	

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalizatio n	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
San Francisco County						X
San Joaquin County						X
San Luis Obispo County						X
San Mateo County	X	X		X		
Santa Barbara County						X
Santa Clara County	X	X	X	X	X	
Santa Cruz County	X	X		X		
Shasta County		X		X		
Sierra County						X
Siskiyou County						X
Solano County	X	X		X		
Sonoma County	X	X	X	X	X	
Stanislaus County	X	X	X	X	X	
Sutter County	X	X	X	X		
Tehama County						X
Trinity County				X		
Tulare County						X
Tuolumne County	X	X	X	X		
Ventura County	X	X	X	X	X	
Yolo County						X

LGAs	Children Under the Age of 21	Medically Fragile Individuals	Individuals at Risk of Institutionalizatio n	Individuals at Jeopardy of Negative Health or Psycho-Social Outcomes	Individuals with a Communicable Disease	LGAs not Participating in TCM
Yuba County						X
City of Berkeley	X	X	X	X	X	
City of Long Beach	X	X	X	X	X	
Total	**23**	**21**	**14**	**29**	**13**	**33**

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

GAVIN NEWSOM
GOVERNOR

Medi-Cal Community Supports, or In Lieu of Services (ILOS) , Policy Guide

December 2021

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Table of Contents

I. Introduction to Community Supports (ILOS)

California Advancing and Innovating Medi-Cal (CalAIM), establishes the framework to address social determinants of health and improve health equity statewide. A key feature of CalAIM is the introduction of a menu of Community Supports, or in lieu of services (ILOS), in managed care.

What are Community Supports?

Community Supports are services or settings that MCPs may offer in place of services or settings covered under the California Medicaid State Plan and that are a medically appropriate, cost-effective alternative to a State Plan Covered Service. Community Supports are optional for MCPs to offer and for Members to utilize. MCPs may not require Members to use a Community Support instead of a service or setting listed in the Medicaid State Plan.

This Program Guide

Community Supports are a significant change and a high priority for DHCS. DHCS recognizes the work California MCPs and communities will be doing to operationalize these new initiatives under CalAIM and transition smoothly services provided under the Whole Person Care Pilots and Health Home Program even as they continue to address the COVID-19 Public Health Emergency.

Throughout 2021, DHCS is offering a range of technical assistance and support including detailed implementation requirements and guidance presented in this Program Guide. In addition, DHCS is making available materials posted on the DHCS CalAIM ECM and Community Supports website, webinars, non-binding Community Supports pricing information, and other opportunities for discussion to support the implementation of these initiatives. All information provided in this fact sheet is preliminary and subject to change. This Program Guide is for informational purposes and is not intended to replace future guidance and state and/or federal requirements.

For specific questions about Community Supports, please submit to: CalAIMECMILOS@dhcs.ca.gov. Questions about CalAIM generally should be submitted to: CalAIM@dhcs.ca.gov.

An FAQ which provides up-to-date information about the Community Supports implementation and will be updated regularly and is available from the Community Supports Resource Directory.

Requirements for Providing Community Supports

Pursuant to 42 CFR 438.3, MCPs may not provide Community Supports without first applying to the State and obtaining State approval to offer the Community Support by demonstrating all of the requirements will be met. MCPs may voluntarily agree to provide any service to a Member outside of an approved Community Supports construct; however, the cost of any such voluntary services may not be included in determining MCP rates.

Once approved by DHCS, the Community Support will be added to the MCP's contract and posted on the DHCS website as a State-Approved ILOS.

Community Supports may be offered by MCPs beginning January 1, 2022. Additional Community Supports may be added thereafter on a 6-month cadence.

II. What are Community Supports, or ILOS?

December 21, 2021

Introduction

CalAIM is a new initiative by the Department of Health Care Services (DHCS) to improve the quality of life and health outcomes of Medi-Cal beneficiaries by implementing broad delivery system, programmatic, and payment system reforms. A key feature of CalAIM is the introduction of a new menu of in lieu of services (ILOS), or Community Supports, which, at the option of a Medi-Cal managed care health plan (MCP) and a Member, can substitute for covered Medi-Cal services as cost-effective alternatives. MCPs will be responsible for administering Community Supports. For more information about CalAIM, see DHCS' Revised CalAIM Proposal released on 1/8/21.[1]

Overview of Community Supports

Community Supports are medically appropriate and cost-effective alternatives to services covered under the State Plan. Federal regulation allows states permit Medicaid managed care organizations to offer Community Supports as an option to Members.[2] Community Supports can substitute for and potentially decrease utilization of a range of covered Medi-Cal benefits, such as hospital care, nursing facility care, and emergency department (ED) use.

Community Supports are an important part of care delivery for Members enrolled in Enhanced Care Management (ECM), another CalAIM initiative that will address the clinical and non-clinical needs of high-need, high-cost Medi-Cal Members through systematic coordination of services and comprehensive care management.[3] As such, DHCS encourages MCPs to offer a robust menu of 14 pre-approved Community Supports to comprehensively address the needs of Members—including those with the most complex challenges affecting health such as homelessness, unstable and unsafe housing, food insecurity, and/or other social needs.

By design, the list of pre-approved Community Supports are drawn in part from the foundational work done as part of the Whole Person Care (WPC) Pilots and Health Home Program (HHP). A key goal of Community Supports is to allow Members to obtain care in the least restrictive setting possible and to keep them in the community as medically appropriate. Community Supports will build on WPC and HHP efforts and activities and expand access to services that were previously available only through home and community-based services initiatives while addressing health-related social needs.

MCPs will have the opportunity to provide details on their elected Community Supports to DHCS as part of their Model of Care (MOC) responses to DHCS. MCPs in all Counties are encouraged to offer one or more of the following Community Supports starting on January 1, 2022:[4]

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[1] Revised CalAIM Proposal, January 2021.
[2] 42 CFR 438.3(e)(2).
[3] ECM Fact Sheet
[4] See the Community Supports Service Descriptions for more detail about each Community Support option.

- Housing Transition Navigation Services;
- Housing Deposits;
- Housing Tenancy and Sustaining Services;
- Short-Term Post-Hospitalization Housing;
- Recuperative Care (Medical Respite);
- Respite Services;
- Day Habilitation Programs;
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for the Elderly (RCFE) and Adult Residential Facilities (ARF);
- Community Transition Services/Nursing Facility Transition to a Home;
- Personal Care and Homemaker Services;
- Environmental Accessibility Adaptations (Home Modifications);
- Medically-Supportive Food/Meals/Medically Tailored Meals;
- Sobering Centers; and
- Asthma Remediation.

Community Supports are Optional, but Strongly Encouraged

MCPs are strongly encouraged to elect to offer some or all of these pre-approved Community Supports and are expected to detail their Community Supports offerings in their MOC. As part of the MOC response, MCPs will describe which Community Supports they will offer, the date each elected Community Support is expected to launch, and the MCP's plans for operationalizing the Community Support including the Community Support provider network. DHCS expects that MCPs in WPC and HHP counties will offer the pre-approved Community Supports that correspond to the services previously offered through those programs to ensure a seamless transition for those Members. MCPs may propose additional Community Supports to DHCS for review and approval. MCPs may choose to offer different Community Supports in different Counties. MCPs may add or remove Community Supports at defined intervals: every six (6) months for an addition and annually for removal of a previously offered Community Support.

Community Supports Implementation Timeline

MCPs in all Counties may launch pre-approved Community Supports beginning January 1, 2022. DHCS strongly encourages all MCPs to begin offering Community Supports at this time. The timely offering of Community Supports will help to improve care for Members, support the goals of CalAIM, and contribute to the smooth transition of Members receiving services through WPC Pilots into Medi-Cal managed care.

III. Community Supports – Service Definitions

Community Supports are alternative services covered under the Medi-Cal State Plan but are delivered by a different provider or in a different setting than is described in the State Plan. Community Supports can only be covered if: 1) the State determines they are medically-appropriate and cost-effective substitutes or settings for the State Plan service, 2) Members are not required to use the Community Supports and 3) the Community Supports are authorized and identified in the managed care plan contracts.

Each set of pre-approved services is described in detail below:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Respite Services
- Day Habilitation Programs
- Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF)
- Community Transition Services/Nursing Facility Transition to a Home
- Personal Care and Homemaker Services
- Environmental Accessibility Adaptations (Home Modifications)
- Medically-Supportive Food/Meals/Medically Tailored Meals
- Sobering Centers
- Asthma Remediation

Housing Transition Navigation Services

Description/Overview

Housing transition services assist Members with obtaining housing and include:

1. Conducting a tenant screening and housing assessment that identifies the member's preferences and barriers related to successful tenancy. The assessment may include collecting information on the member's housing needs, potential housing transition barriers, and identification of housing retention barriers.
2. Developing an individualized housing support plan based upon the housing assessment that addresses identified barriers, includes short- and long-term measurable goals for each issue, establishes the member's approach to meeting the goal, and identifies when other providers or services, both reimbursed and not reimbursed by Medi-Cal, may be required to meet the goal.
3. Searching for housing and presenting options.
4. Assisting in securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
5. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
6. Identifying and securing available resources to assist with subsidizing rent (such as HUD's Housing Choice Voucher Program (Section 8), or state and local assistance programs) and matching available rental subsidy resources to Members.
7. Identifying and securing resources to cover expenses, such as security deposit, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.[5]
8. Assisting with requests for reasonable accommodation, if necessary.[6]
9. Landlord education and engagement
10. Ensuring that the living environment is safe and ready for move-in.
11. Communicating and advocating on behalf of the Member with landlords.

[5] Actual payment of these housing deposits and move-in expenses is a separate in-lieu service under Housing Deposits.

[6] Related to expenses incurred by the housing navigator supporting the member moving into the home

12. Assisting in arranging for and supporting the details of the move.
13. Establishing procedures and contacts to retain housing, including developing a housing support crisis plan that includes prevention and early intervention services when housing is jeopardized.[7]
14. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move in day.
15. Identifying, coordinating, securing, or funding environmental modifications to install necessary accommodations for accessibility (see Environmental Accessibility Adaptations Community Support).

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Members may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. Examples of best practices include Housing First Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve additional coordination with other entities to ensure the individual has access to supports needed for successful tenancy. These entities may include County Health, Public Health, Substance Use, Mental Health and Social Services Departments; County and City Housing Authorities; Continuums of Care and Coordinated Entry System; Sheriff's Department and Probation Officers, as applicable and to the extent possible; local legal service programs, community-based organizations housing providers, local housing agencies, and housing development agencies. For Members who will need rental subsidy support to secure permanent housing, the services will require close coordination with local Coordinated Entry Systems, homeless services authorities, public housing authorities, and other operators of local rental subsidies. Some housing assistance (including recovery residences and emergency assistance or rental subsidies for Full Service Partnership Members) is also funded by county behavioral health agencies, and Medi-Cal managed care plans and their contracted Community Supports providers should expect to coordinate access to these housing resources through county behavioral health when appropriate.

Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless service to Members experiencing homelessness entering the Housing Transition Navigation Services Community Support.

[7] The services associated with the crisis plan are a separate in-lieu service under Housing Tenancy and Sustaining Services.

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Services do not include the provision of room and board or payment of rental costs. Coordination with local entities is crucial to ensure that available options for room and board or rental payments are also coordinated with housing services and supports.

Eligibility (Population Subset)

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the “Homeless” definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

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terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Transition Navigation services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions and Limitations

Housing Transition/Navigation services must be identified as reasonable and necessary in the individual's individualized housing support plan. Service duration can be as long as necessary.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contractwith, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated experience with providing housing-related services and supports and may include providers such as:

- Vocational services agencies;
- Providers of services for individuals experiencing homelessness;
- Life skills training and education providers;
- County agencies;
- Public hospital systems;
- Mental health or substance use disorder treatment providers, including county behavioral health agencies;
- Social services agencies;
- Affordable housing providers;
- Supportive housing providers; and
- Federally qualified health centers and rural health clinics.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting

the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be an Community Supports Provider. Members who meet the eligibility requirements for Housing Transition/Navigation services should also be assessed for enhanced care management and Housing and Tenancy Support Services (if provided in their county). When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers. When members receive more than one of these services, the managed care plan should ensure it is coordinated by an enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by members and to improve overall care coordination and management.[8]

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experience working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations.

[8] One exception to this is for benefits advocacy, which may require providers with a specialized skill set.

Housing Deposits

Description/Overview

Housing Deposits assist with identifying, coordinating, securing, or funding one-time services and modifications necessary to enable a person to establish a basic household that do not constitute room and board, such as:

1. Security deposits required to obtain a lease on an apartment or home.
2. Set-up fees/deposits for utilities or service access and utility arrearages.
3. First month coverage of utilities, including but not limited to telephone, gas, electricity, heating, and water.
4. First month's and last month's rent as required by landlord for occupancy.
5. Services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy.
6. Goods such as an air conditioner or heater, and other medically-necessary adaptive aids and services, designed to preserve an individuals' health and safety in the home such as hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies etc., that are necessary to ensure access and safety for the individual upon move-in to the home.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require, and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Services do not include the provision of room and board or payment of ongoing rental costs beyond the first and last month's coverage as noted above.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or

- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals.

Restrictions and Limitations

Housing Deposits are available once in an individual's lifetime. Housing Deposits can only be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Deposits would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the Member is unable to meet such expense.

Individuals must also receive Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment and individualized housing support plan) in conjunction with this service.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing and Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

The entity that is coordinating an individual's Housing Transition Navigation Services, or the Medi-Cal managed care plan case manager, care coordinator, or housing navigator may coordinate these services and pay for them directly (e.g., to the landlord, utility company, pest control company, etc.) or subcontract the services.

Providers must have demonstrated or verifiable experience and expertise with providing these unique services.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level

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enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

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Housing Tenancy and Sustaining Services

Description/Overview

This service provides tenancy and sustaining services, with a goal of maintaining safe and stable tenancy once housing is secured.

Services include:

1. Providing early identification and intervention for behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
2. Education and training on the role, rights, and responsibilities of the tenant and landlord.
3. Coaching on developing and maintaining key relationships with landlords/property managers with a goal of fostering successful tenancy.
4. Coordination with the landlord and case management provider to address identified issues that could impact housing stability.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action including developing a repayment plan or identifying funding in situations in which the Member owes back rent or payment for damage to the unit.
6. Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
7. Assisting with benefits advocacy, including assistance with obtaining identification and documentation for SSI eligibility and supporting the SSI application process. Such service can be subcontracted out to retain needed specialized skillset.
8. Assistance with the annual housing recertification process.
9. Coordinating with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
10. Continuing assistance with lease compliance, including ongoing support with activities related to household management.
11. Health and safety visits, including unit habitability inspections[9].
12. Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized (e.g., assisting with reasonable accommodation requests that were not initially required upon move-in).

[9] Does not include housing quality inspections.

13. Providing independent living and life skills including assistance with and training on budgeting, including financial literacy and connection to community resources.

The services provided should be based on individualized assessment of needs and documented in the individualized housing support plan. Individuals may require and access only a subset of the services listed above.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

The services may involve coordination with other entities to ensure the individual has access to supports needed to maintain successful tenancy. Final program guidelines should adopt, as a standard, the demonstrated need to ensure seamless serving to Members experiencing homelessness entering the Housing Tenancy and Sustaining Services Community Support.

Services do not include the provision of room and board or payment of rental costs.

Eligibility (Population Subset)

- Any individual who received Housing Transition/Navigation Services Community Support in counties that offer Housing Transition/Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system designed to use information to identify highly vulnerable individuals with disabilities and/or one or more serious chronic conditions and/or serious mental illness, institutionalization or requiring residential services as a result of a substance use disorder and/or is exiting incarceration; or
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals; or
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the

area, as determined by HUD;

- Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and

    - Meets one of the following conditions:

        - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;

        - Is living in the home of another because of economic hardship;

        - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;

    - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;

    - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;

    - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or

    - Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of

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the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Housing Tenancy and Sustaining services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);
- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

These services are available from the initiation of services through the time when the individual's housing support plan determines they are no longer needed. They are only available for a single duration in the individual's lifetime. Housing Tenancy and Sustaining Services can be approved one additional time with documentation as to what conditions have changed to demonstrate why providing Housing Tenancy and Sustaining Services would be more successful on the second attempt. Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services. Service duration can be as long as necessary.

These services must be identified as reasonable and necessary in the individual's individualized housing support plan and are available only when the enrollee is unable to successfully maintain longer-term housing without such assistance.

Many individuals will have also received Housing Transition/Navigation services (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with this service, but it is not a prerequisite for eligibility.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

Providers must have demonstrated or verifiable experience or expertise with providing housing-related services and supports and may include providers such as:

- Vocational services agencies
- Providers of services for individuals experiencing homelessness
- Life skills training and education providers
- County agencies
- Public hospital systems
- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Supportive housing providers
- Federally qualified health centers and rural health clinics

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

If the Medi-Cal managed care plan case manager, care coordinator or housing navigator is providing the service, that individual must have demonstrated experiencing working with individuals experiencing homelessness or with the provision of housing-related services and supports to vulnerable populations. Medi-Cal managed care plans should coordinate with county homelessness entities to provide these services.

Members who meet the eligibility requirements for Housing and Tenancy Support Services should also be assessed for enhanced care management and may have received Housing Transition/Navigation services (if provided in their county). When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers. When Members receive more than one of these services, the managed care plan should ensure coordination by an

enhanced care management provider whenever possible to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

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Short-Term Post-Hospitalization Housing

Description/Overview

Short-Term Post-Hospitalization housing provides Members who do not have a residence and who have high medical or behavioral health needs with the opportunity to continue their medical/psychiatric/substance use disorder recovery immediately after exiting an inpatient hospital (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, nursing facility, or recuperative care and avoid further utilization of State plan services.[10]

This setting must provide individuals with ongoing supports necessary for recuperation and recovery such as gaining (or regaining) the ability to perform activities of daily living, receiving necessary medical/psychiatric/substance use disorder care, case management, and beginning to access other housing supports such as Housing Transition Navigation.[11]

This setting may include an individual or shared interim housing setting, where residents receive the services described above.

Members must be offered Housing Transition Navigation supports during the period of Short-Term Post-Hospitalization housing to prepare them for transition from this setting. These services should include a housing assessment and the development of individualized housing support plan to identify preferences and barriers related to successful housing tenancy after Short-Term Post-Hospitalization housing.[12]

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals exiting recuperative care.
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility and who meet any of the following criteria:
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of

[10] Up to 90 days of recuperative care is available under specified circumstances as a separate in-lieu of service.
[11] Housing Transition/Navigation is a separate Community Support.
[12] The development of a housing assessment and individualized support plan are covered as a separate in-lieu service under Housing Transition/Navigation Services.

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days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals;

- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance;
            - Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
            - Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
            - Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or

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institution); or

- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Short-Term Post-Hospitalization services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);
- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

In addition to meeting one of these criteria at a minimum, individuals must have medical/behavioral health needs such that experiencing homelessness upon discharge from the hospital, substance use or mental health treatment facility, correctional facility, nursing facility, or recuperative care would likely result in hospitalization, re-hospitalization, or institutional readmission.

Restrictions/Limitations

Short-Term Post-Hospitalization services are available once in an individual's lifetime and are not to exceed a duration of six (6) months (but may be authorized for a shorter period based on individual needs). Plans are expected to make a good faith effort to review information available to them to determine if individual has previously received services.

The service is only available if enrollee is unable to meet such an expense.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities
- Supportive Housing providers
- County agencies
- Public Hospital Systems
- Social service agencies
- Providers of services for individuals experiencing homelessness

Facilities may be unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for short-term post-hospitalization housing. Medi-Cal managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Recuperative Care (Medical Respite)

Description/Overview

Recuperative care, also referred to as medical respite care, is short-term residential care for individuals who no longer require hospitalization, but still need to heal from an injury or illness (including behavioral health conditions) and whose condition would be exacerbated by an unstable living environment. An extended stay in a recovery care setting allows individuals to continue their recovery and receive post-discharge treatment while obtaining access to primary care, behavioral health services, case management and other supportive social services, suchas transportation, food, and housing.

At a minimum, the service will include interim housing with a bed and meals and ongoing monitoring of the individual's ongoing medical or behavioral health condition (e.g., monitoring of vital signs, assessments, wound care, medication monitoring). Based on individual needs, the service may also include:

1. Limited or short-term assistance with Instrumental Activities of Daily Living &/or ADLs
2. Coordination of transportation to post-discharge appointments
3. Connection to any other on-going services an individual may require including mental health and substance use disorder services
4. Support in accessing benefits and housing
5. Gaining stability with case management relationships and programs

Recuperative care is primarily used for those individuals who are experiencing homelessness or those with unstable living situations who are too ill or frail to recover from an illness (physical or behavioral health) or injury in their usual living environment; but are not otherwise ill enough to be in a hospital.

The services provided to an individual while in recuperative care should not replace or be duplicative of the services provided to members utilizing the enhanced care management program. Recuperative Care may be utilized in conjunction with other housing Community Supports. Whenever possible, other available housing Community Supports should be provided to Members onsite in the recuperative care facility. When enrolled in enhanced care management, Community Supports should be managed in coordination with enhanced care management providers.

The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

- Individuals who are at risk of hospitalization or are post-hospitalization, and
- Individuals who live alone with no formal supports; or
- Individuals who face housing insecurity or have housing that would jeopardize their health and safety without modification. [13]
- Individuals who meet the Housing and Urban Development (HUD) definition of homeless as defined in Section 91.5 of Title 24 of the Code of Federal Regulations (including those exiting institutions but not including any limits on the number of days in the institution) and who are receiving enhanced care management, or who have one or more serious chronic conditions and/or serious mental illness and/or is at risk of institutionalization or requiring residential services as a result of a substance use disorder. For the purpose of this service, qualifying institutions include hospitals, correctional facilities, mental health residential treatment facility, substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease and State Hospitals;
- Individuals who meet the HUD definition of at risk of homelessness as defined in Section 91.5 of Title 24 of the Code of Federal Regulations as:
    - (1) An individual or family who:
        - Has an annual income below 30 percent of median family income for the area, as determined by HUD;
        - Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the "Homeless" definition in this section; and
            - Meets one of the following conditions:
                - Has moved because of economic reasons two or more times during the 60 days immediately preceding the application for homelessness prevention assistance;
                - Is living in the home of another because of economic hardship;
                - Has been notified in writing that their right to occupy their current housing or living situation will be

[13] For this population, the service could be coordinated with home modifications (which are covered as a separate Community Support) and serve as a temporary placement until the Member can safely return home.

terminated within 21 days after the date of application for assistance;

- Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by federal, State, or local government programs for low-income individuals;
- Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5 people per room, as defined by the U.S. Census Bureau;
- Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
- Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

- (2) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e-2(6)), section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or
- (3) A child or youth who does not qualify as "homeless" under this section, but qualifies as "homeless" under section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

Individuals who are determined to be at risk of experiencing homelessness are eligible to receive Recuperative Care services if they have significant barriers to housing stability and meet at least one of the following:

- Have one or more serious chronic conditions;
- Have a Serious Mental Illness;
- Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder o Have a Serious Emotional Disturbance (children and adolescents);

- Are receiving Enhanced Care Management; or
- Are a Transition-Age Youth with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

Restrictions/Limitations

Recuperative care/medical respite is an allowable Community Supports service if it is 1) necessary to achieve or maintain medical stability and prevent hospital admission or re-admission, which may require behavioral health interventions, 2) not more than 90 days in continuous duration, and 3) does not include funding for building modification or building rehabilitation.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Interim housing facilities with additional on-site support
- Shelter beds with additional on-site support
- Converted homes with additional on-site support
- County directly operated or contracted recuperative care facilities

Facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Managed care plans can adopt or adapt local or national standards for recuperative care or interim housing. Managed care plans shall monitor the provision of all the services included above.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Respite Services

Description/Overview

Respite services are provided to caregivers of Members who require intermittent temporary supervision. The services are provided on a short-term basis because of the absence or need for relief of those persons who normally care for and/or supervise them and are non-medical in nature. This service is distinct from medical respite/recuperative care and is rest for the caregiver only.

Respite services can include any of the following:

1. Services provided by the hour on an episodic basis because of the absence of or need for relief for those persons normally providing the care to individuals.
2. Services provided by the day/overnight on a short-term basis because of the absence of or need for relief for those persons normally providing the care to individuals.
3. Services that attend to the Member's basic self-help needs and other activities of daily living, including interaction, socialization and continuation of usual daily routines that would ordinarily be performed by those persons who normally care for and/or supervise them.

Home Respite services are provided to the Member in his or her own home or another location being used as the home.

Facility Respite services are provided in an approved out-of-home location.

Respite should be made available when it is useful and necessary to maintain a person in their own home and to preempt caregiver burnout to avoid institutional services for which the Medi-Cal managed care plan is responsible.

Eligibility (Population Subset)

Individuals who live in the community and are compromised in their Activities of Daily Living (ADLs) and are therefore dependent upon a qualified caregiver who provides most of their support, and who require caregiver relief to avoid institutional placement.

Other subsets may include children who previously were covered for Respite Services under the Pediatrics Palliative Care Waiver, foster care program beneficiaries, Members enrolled in California Children's Services, and Genetically Handicapped Persons Program (GHPP), and Members with Complex Care Needs.

Restrictions/Limitations

In the home setting, these services, in combination with any direct care services the Member is receiving, may not exceed 24 hours per day of care.

Service limit is up to 336 hours per calendar year. The service is inclusive of all in-home and in-facility services. Exceptions to the 336 hour per calendar year limit can be made, with Medi-Cal managed care plan authorization, when the caregiver experiences an episode, including medical treatment and hospitalization that leaves a Medicaid member without their caregiver. Respite support provided during these episodes can be excluded from the 336-hour annual limit.

This service is only to avoid placements for which the Medi-Cal managed care plan would be responsible.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health or respite agencies to provide services in:
  - Private residence
  - Residential facility approved by the State, such as, Congregate Living Health Facilities (CLHFs)
  - Providers contracted by county behavioral health

Other community settings that are not a private residence, such as:

- Adult Family Home/Family Teaching Home
- Certified Family Homes for Children
- County Agencies
- Residential Care Facility for the Elderly (RCFE)
- Child Day Care Facility; Child Day Care Center; Family Child Care Home
- Respite Facility; Residential Facility: Small Family Homes (Children Only)
- Respite Facility; Residential Facility: Foster Family Agency (FFA)-Certified Family Homes (Children Only)
- Respite Facility; Residential Facility: Adult Residential Facilities (ARF)
- Respite Facility; Residential Facility: Group Homes (Children Only)
- Respite Facility; Residential Facility: Family Home Agency (FHA): Adult Family Home (AFH)/Family Teaching Home (FTH)
- Respite Facility; Residential Facility: Adult Residential Facility for Persons with

Special Health Care Needs

- Respite Facility; Residential Facility: Foster Family Homes (FFHs) (Children Only)
- Short-term Residential Therapeutic Program Providers or other care providers who are serving youth with complex needs

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Day Habilitation Programs

Description/Overview

Day Habilitation Programs are provided in a Member's home or an out-of-home, non-facility setting. The programs are designed to assist the Member in acquiring, retaining, and improving self-help, socialization, and adaptive skills necessary to reside successfully in the person's natural environment. The services are often considered as peer mentoring when provided by an unlicensed caregiver with the necessary training and supervision. For Members experiencing homelessness who are receiving enhanced care management or other Community Supports, day habilitation programs can provide a physical location for Members to meet with and engage with these providers. When possible, these services should be provided by the same entity to minimize the number of care/case management transitions experienced by Members and to improve overall care coordination and management.

Day Habilitation Program services include, but are not limited to, training on:

1. The use of public transportation;
2. Personal skills development in conflict resolution;
3. Community participation;
4. Developing and maintaining interpersonal relationships;
5. Daily living skills (cooking, cleaning, shopping, money management); and,
6. Community resource awareness such as police, fire, or local services to support independence in the community.

Programs may include assistance with, but not limited to, the following:

1. Selecting and moving into a home;[14]
2. Locating and choosing suitable housemates;
3. Locating household furnishings;
4. Settling disputes with landlords;[15]
5. Managing personal financial affairs;
6. Recruiting, screening, hiring, training, supervising, and dismissing personal attendants;
7. Dealing with and responding appropriately to governmental agencies and personnel;
8. Asserting civil and statutory rights through self-advocacy;

[14] Refer to the Housing Transition/Navigation Services Community Support
[15] Refer to the Housing- Tenancy and Sustaining Services Community Support

9. Building and maintaining interpersonal relationships, including a circle of support;
10. Coordination with Medi-Cal managed care plan to link Member to any Community Supports and/or enhanced care management services for which the Member may be eligible;
11. Referral to non-Community Supports housing resources if Member does not meet Housing Transition/Navigation Serv ices Community Support eligibility criteria;
12. Assistance with income and benefits advocacy including General Assistance/ General Relief and SSI if Member is not receiving these services through Community Supports or Enhanced Care Management; and
13. Coordination with Medi-Cal managed care plan to link Member to health care, mental health services, and substance use disorder services based on the individual needs of the Member for Members who are not receiving this linkage through Community Supports or enhanced care management.

The services provided should utilize best practices for Members who are experiencing homelessness or formerly experienced homelessness including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Program services are available for as long as necessary. Services can be provided continuously, or through intermittent meetings, in an individual or group setting.

Eligibility (Population Subset)

Individuals who are experiencing homelessness, individuals who exited homelessness and entered housing in the last 24 months, and individuals at risk of homelessness or institutionalization whose housing stability could be improved through participation in a day habilitation program.

Restrictions/Limitations

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Mental health or substance use disorder treatment providers, including county behavioral health agencies
- Licensed Psychologists
- Licensed Certified Social Workers

- Registered Nurses
- Home Health Agencies
- Professional Fiduciary
- Vocational Skills Agencies

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Nursing Facility Transition/Diversion to Assisted Living Facilities, such as Residential Care Facilities for Elderly and Adult Residential Facilities

Description/Overview

Nursing Facility Transition/Diversion services assist individuals to live in the community and/or avoid institutionalization when possible.

The goal is to both facilitate nursing facility transition back into a home-like, community setting and/or prevent skilled nursing admissions for Members with an imminent need for nursing facility level of care (LOC). Individuals have a choice of residing in an assisted living setting as an alternative to long-term placement in a nursing facility when they meet eligibility requirements.

The assisted living provider is responsible for meeting the needs of the Member, including Activities of Daily Living (ADLs), Instrumental ADLs (IADLs), meals, transportation, and medication administration, as needed.

For individuals who are transitioning from a licensed health care facility to a living arrangement in a Residential Care Facilities for Elderly (RCFE) and Adult Residential Facilities (ARF). Includes wrap-around services, including: assistance w/ ADLs and IADLs as needed, companion services, medication oversight, and therapeutic social and recreational programming provided in a home-like environment. Includes 24-hour direct care staff on-site to meet scheduled unpredictable needs in a way that promotes maximum dignity and independence, and to provide supervision, safety, and security. Allowable expenses are those necessary to enable a person to establish a community facility residence (except room and board), including, but not limited to:

1. Assessing the Member's housing needs and presenting options.[16]
2. Assessing the service needs of the Member to determine if the Member needs enhanced onsite services at the RCFE/ARF so the Member can be safely and stably housed in an RCFE/ARF.
3. Assisting in securing a facility residence, including the completion of facility applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
4. Communicating with facility administration and coordinating the move.
5. Establishing procedures and contacts to retain facility housing.
6. Coordinating with the Medi-Cal managed care plan to ensure that the needs of Members who need enhanced services to be safely and stably housed in RCFE/ARF settings have Community Supports and/or Enhanced Care Management services that provide the necessary enhanced services.
    A. Managed care plans may also fund RCFE/ARF operators directly to provide these enhanced services.

[16] Refer to Housing Transition/Navigation Services Community Support for additional details.

Eligibility (Population Subset)

A. For Nursing Facility Transition:
   1. Has resided 60+ days in a nursing facility;
   2. Willing to live in an assisted living setting as an alternative to a Nursing Facility; and
   3. Able to reside safely in an assisted living facility with appropriate and cost-effective supports.

B. For Nursing Facility Diversion:
   1. Interested in remaining in the community;
   2. Willing and able to reside safely in an assisted living facility with appropriate and cost-effective supports and services; and
   3. Must be currently receiving medically necessary nursing facility LOC or meet the minimum criteria to receive nursing facility LOC services and in lieu of going into a facility, is choosing to remain in the community and continue to receive medically necessary nursing facility LOC services at an Assisted Living Facility.

Restrictions/Limitations

Individuals are directly responsible for paying their own living expenses.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services in a culturally and linguistically appropriate manner. The below list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with but is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- ARF/RCFE Operators

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or

delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

RCFE/ARFs are licensed and regulated by the California Department of Social Services, Community Care Licensing (CCL) Division.

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Community Transition Services/Nursing Facility Transition to a Home

Description/Overview

Community Transition Services/Nursing Facility Transition to a Home helps individuals to live in the community and avoid further institutionalization.

Community Transition Services/Nursing Facility Transition to a Home are non-recurring set-up expenses for individuals who are transitioning from a licensed facility to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and include:

1. Assessing the Member's housing needs and presenting options.[17]
2. Assisting in searching for and securing housing, including the completion of housing applications and securing required documentation (e.g., Social Security card, birth certificate, prior rental history).
3. Communicating with landlord (if applicable) and coordinating the move.
4. Establishing procedures and contacts to retain housing.
5. Identifying, coordinating, securing, or funding non-emergency, non-medical transportation to assist Members' mobility to ensure reasonable accommodations and access to housing options prior to transition and on move-in day.
6. Identifying the need for and coordinating funding for environmental modifications to install necessary accommodations for accessibility.[18]

Identifying the need for and coordinating funding for services and modifications necessary to enable a person to establish a basic household that does not constitute room and board, such as: security deposits required to obtain a lease on an apartment or home; set-up fees for utilities or service access; first month coverage of utilities, including telephone, electricity, heating and water; services necessary for the individual's health and safety, such as pest eradication and one-time cleaning prior to occupancy; home modifications, such as an air conditioner or heater; and other medically-necessary services, such as hospital beds, Hoyer lifts, etc. to ensure access and reasonable accommodations.[19]

Eligibility (Population Subset)

1. Currently receiving medically necessary nursing facility Level of Care (LOC)

[17] Refer to the Housing Transition/Navigation Services and/or Housing Tenancy/Sustaining Services Community Support for additional details.

[18] Refer to the Environmental Accessibility Adaptations and/or Asthma Remediation Community Support for additional details.

[19] Refer to the Housing Deposits Community Support for additional details.

services and, in lieu of remaining in the nursing facility or Medical Respite setting, is choosing to transition home and continue to receive medically necessary nursing facility LOC services; and

2. Has lived 60+ days in a nursing home and/or Medical Respite setting; and
3. Interested in moving back to the community; and
4. Able to reside safely in the community with appropriate and cost-effective supports and services.

Restrictions/Limitations

- Community Transition Services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances or items that are intended for purely diversionary/recreational purposes.
- Community Transition Services are payable up to a total lifetime maximum amount of $7,500.00. The only exception to the $7,500.00 total maximum is if the Member is compelled to move from a provider-operated living arrangement to a living arrangement in a private residence through circumstances beyond his or her control.
- Community Transition Services must be necessary to ensure the health, welfare, and safety of the Member, and without which the Member would be unable to move to the private residence and would then require continued or re- institutionalization.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. The list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Case management agencies
- Home Health agencies
- Medi-Cal managed care plans
- County mental health providers
- 1915c HCBA/ALW providers
- CCT/Money Follows the Person providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Personal Care and Homemaker Services

Description/Overview

Personal Care Services and Homemaker Services provided for individuals who need assistance with Activities of Daily Living (ADLs) such as bathing, dressing, toileting, ambulation, or feeding. Personal Care Services can also include assistance with Instrumental Activities of Daily Living (IADLs) such as meal preparation, grocery shopping, and money management.

Includes services provided through the In-Home Support Services (In-Home Supportive Services) program include house cleaning, meal preparation, laundry, grocery shopping, personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services), accompaniment to medical appointments, and protective supervision for the mentally impaired.

Services also include help with tasks such as cleaning and shopping, laundry, and grocery shopping. Personal Care and Homemaker programs aid individuals who could otherwise not remain in their homes.

The Personal Care and Homemaker Services Community Support can be utilized:

- Above and beyond any approved county In-Home Supportive Services hours, when additional hours are required and if In-Home Supportive Services benefits are exhausted; and
- As authorized during any In-Home Supportive Services waiting period (Member must be already referred to In-Home Supportive Services); this approval time period includes services prior to and up through the In-Home Supportive Services application date.
- For Members not eligible to receive In-Home Supportive Services, to help avoid a short-term stay in a skilled nursing facility (not to exceed 60 days).

Similar services available through In-Home Supportive Services should always be utilized first. These Personal Care and Homemaker services should only be utilized if appropriate and if additional hours/supports are not authorized by In-Home Supportive Services.

Eligibility (Population Subset)

- Individuals at risk for hospitalization, or institutionalization in a nursing facility; or
- Individuals with functional deficits and no other adequate support system; or
- Individuals approved for In-Home Supportive Services. Eligibility criteria can be found at: http://www.cdss.ca.gov/In-Home-Supportive-Services.

Restrictions/Limitations

This service cannot be utilized in lieu of referring to the In-Home Supportive Services program. Member must be referred to the In-Home Supportive Services program when they meet referral criteria.

If a Member receiving Personal Care and Homemaker services has any change in their current condition, they must be referred to In-Home Supportive Services for reassessment and determination of additional hours. Members may continue to receive the Personal Care and Homemaker Services Community Support during this reassessment waiting period.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home health agencies
- County agencies
- Personal care agencies
- AAA (Area Agency on Aging)

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Environmental Accessibility Adaptations (Home Modifications)

Description/Overview

Environmental Accessibility Adaptations (EAAs also known as Home Modifications) are physical adaptations to a home that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function with greater independence in the home: without which the Member would require institutionalization.

Examples of environmental accessibility adaptions include:

- Ramps and grab-bars to assist Members in accessing the home;
- Doorway widening for Members who require a wheelchair;
- Stair lifts;
- Making a bathroom and shower wheelchair accessible (e.g., constructing a roll-in shower).
- Installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies of the Member; and
- Installation and testing of a Personal Emergency Response System (PERS) for Members who are alone for significant parts of the day without a caregiver and who otherwise require routine supervision (including monthly service costs, as needed).

The services are available in a home that is owned, rented, leased, or occupied by the Member. For a home that is not owned by the Member, the Member must provide written consent from the owner for physical adaptations to the home or for equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.).

When authorizing environmental accessibility adaptations as a Community Support, the managed care plan must receive and document an order from the Member's current primary care physician or other health professional specifying the requested equipment or service as well as documentation from the provider of the equipment or service describing how the equipment or service meets the medical needs of the Member, including any supporting documentation describing the efficacy of the equipment where appropriate. Brochures will suffice in showing the purpose and efficacy of the equipment; however, a brief written evaluation specific to the Member describing how and why the equipment or service meets the needs of the Member will still be necessary.

The managed care plan must also receive and document:

1. A physical or occupational therapy evaluation and report to evaluate the medical necessity of the requested equipment or service unless the managed care plan determines it is appropriate to approve without an evaluation. This should typically come from an entity with no connection to the provider of the requested equipment or service. The physical or occupational therapy evaluation and report should

contain at least the following:

A. An evaluation of the Member and the current equipment needs specific to the Member, describing how/why the current equipment does not meet the needs of the Member;

B. An evaluation of the requested equipment or service that includes a description of how/why it is necessary for the Member *and reduces the risk of institutionalization*. This should also include information on the ability of the Member and/or the primary caregiver to learn about and appropriately use any requested item, and

C. A description of similar equipment used either currently or in the past that has demonstrated to be inadequate for the Member and a description of the inadequacy.

2. If possible, a minimum of two bids from appropriate providers of the requested service, which itemize the services, cost, labor, and applicable warranties; and

3. That a home visit has been conducted to determine the suitability of any requested equipment or service.

The assessment and authorization for EAAs must take place within a 90-day time frame beginning with the request for the EAA, unless more time is required to receive documentation of homeowner consent, or the individual receiving the service requests a longer time frame.

Eligibility (Population Subset)

Individuals at risk for institutionalization in a nursing facility.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of independence and avoiding institutional placement, that service should be used.
- EAAs must be conducted in accordance with applicable State and local building codes.
- EAAs are payable up to a total lifetime maximum of $7,500. The only exceptions to the $7,500 total maximum are if the Member's place of residence changes or if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.
- EAAs may include finishing (e.g., drywall and painting) to return the home to a

habitable condition, but do not include aesthetic embellishments.

- Modifications are limited to those that are of direct medical or remedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Adaptations that add to the total square footage of the home are excluded except when necessary to complete an adaptation (e.g., to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- Before commencement of a physical adaptation to the home or equipment that is physically installed in the home (e.g., grab bars, chair lifts, etc.), the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance. Licensing/Allowable Providers

The Medi-Cal managed care plan may manage these services directly or may coordinate with a provider to manage the service.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Area Agencies on Aging (AAA)
- Local health departments
- Community-based providers and organizations

All EAAs that are physical adaptations to a residence must be performed by an individual holding a California Contractor's License with the exception of a PERS installation, which may be performed in accordance with the system's installation requirements.

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Medically Tailored Meals/Medically-Supportive Food

Description/Overview

Malnutrition and poor nutrition can lead to devastating health outcomes, higher utilization, and increased costs, particularly among Members with chronic conditions. Meals help individuals achieve their nutrition goals at critical times to help them regain and maintain their health. Results include improved Member health outcomes, lower hospital readmission rates, a well-maintained nutritional health status, and increased Member satisfaction.

1. Meals delivered to the home immediately following discharge from a hospital or nursing home when Members are most vulnerable to readmission.
2. Medically-Tailored Meals: meals provided to the Member at home that meet the unique dietary needs of those with chronic diseases.
3. Medically-Tailored meals are tailored to the medical needs of the Member by a Registered Dietitian (RD) or other certified nutrition professional, reflecting appropriate dietary therapies based on evidence-based nutritional practice guidelines to address medical diagnoses, symptoms, allergies, medication management, and/or side effects to ensure the best possible nutrition-related health outcomes.
4. Medically-supportive food and nutrition services, including medically tailored groceries, healthy food vouchers, and food pharmacies.
5. Behavioral, cooking, and/or nutrition education is included when paired with direct food assistance as enumerated above.

Managed care plans have the discretion to define criteria for the level of services determined to be both medically appropriate and cost-effective for Members (e.g. Medically-Tailored meals, groceries, food vouchers, etc.).

Eligibility (Population Subset)

1. Individuals with chronic conditions, such as but not limited to diabetes, cardiovascular disorders, congestive heart failure, stroke, chronic lung disorders, human immunodeficiency virus (HIV), cancer, gestational diabetes, or other high risk perinatal conditions, and chronic or disabling mental/behavioral health disorders.
2. Individuals being discharged from the hospital or a skilled nursing facility or at high risk of hospitalization or nursing facility placement; or
3. Individuals with extensive care coordination needs.

Restrictions/Limitations

- Up to two (2) meals per day and/or medically-supportive food and nutrition services for up to 12 weeks, or longer if medically necessary.
- Meals that are eligible for or reimbursed by alternate programs are not eligible.
- Meals are not covered to respond solely to food insecurities.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Home delivered meal Providers
- Area Agencies on Aging
- Nutritional Education Services to help sustain healthy cooking and eating habits
- Meals on Wheels Providers
- Medically-Supportive Food & Nutrition Providers

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Sobering Centers

Description/Overview

Sobering centers are alternative destinations for individuals who are found to be publicly intoxicated (due to alcohol and/or other drugs) and would otherwise be transported to the emergency department or jail. Sobering centers provide these individuals, primarily those who are homeless or those with unstable living situations, with a safe, supportive environment to become sober.

Sobering centers provide services such as medical triage, lab testing, a temporary bed, rehydration and food service, treatment for nausea, wound and dressing changes, shower and laundry facilities, substance use education and counseling, navigation and warm hand-offs for additional substance use services or other necessary health care services, and homeless care support services.

- When utilizing this service, direct coordination with the county behavioral health agency is required and warm hand-offs for additional behavioral health services are strongly encouraged.
- The service also includes screening and linkage to ongoing supportive services such as follow-up mental health and substance use disorder treatment and housing options, as appropriate.
- This service requires partnership with law enforcement, emergency personnel, and outreach teams to identify and divert individuals to Sobering Centers. Sobering centers must be prepared to identify Members with emergent physical health conditions and arrange transport to a hospital or appropriate source of medical care.
- The services provided should utilize best practices for Members who are experiencing homelessness and who have complex health and/or behavioral health conditions including Housing First, Harm Reduction, Progressive Engagement, Motivational Interviewing, and Trauma-Informed Care.

Eligibility (Population Subset)

Individuals age 18 and older who are intoxicated but conscious, cooperative, able to walk, nonviolent, free from any medical distress (including life threatening withdrawal symptoms or apparent underlying symptoms), and who would otherwise be transported to the emergency department or a jail or who presented at an emergency department and are appropriate to be diverted to a Sobering Center.

Restrictions/Limitations

This service is covered for a duration of less than 24 hours.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

Providers must have experience and expertise with providing these unique services with these unique populations. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Sobering Centers, or other appropriate and allowable substance use disorder facilities. Medi-Cal managed care plans should consult with county behavioral health agencies to ensure these facilities can offer an appropriate standard of care and properly coordinate follow up access to substance use disorder services and other behavioral health services.
- These facilities are unlicensed. Medi-Cal managed care plans must apply minimum standards, subject to review and approval by DHCS, to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

Asthma Remediation[20]

Description/Overview

Environmental Asthma Trigger Remediations are physical modifications to a home environment that are necessary to ensure the health, welfare, and safety of the individual, or enable the individual to function in the home and without which acute asthma episodes could result in the need for emergency services and hospitalization.

Examples of environmental asthma trigger remediations include:

- Allergen-impermeable mattress and pillow dustcovers;
- High-efficiency particulate air (HEPA) filtered vacuums;
- Integrated Pest Management (IPM) services;
- De-humidifiers;
- Air filters;
- Other moisture-controlling interventions;
- Minor mold removal and remediation services;
- Ventilation improvements;
- Asthma-friendly cleaning products and supplies;
- Other interventions identified to be medically appropriate and cost effective.

The services are available in a home that is owned, rented, leased, or occupied by the Member or their caregiver.

When authorizing Asthma Remediation as a Community Support, the managed care plan must receive and document:

- A current licensed health care provider's order specifying the requested remediation(s) for the Member;
- A brief written evaluation specific to the Member describing how and why the remediation(s) meets the needs of the individual, required for cases of "Other interventions identified to be medically appropriate and cost-effective.;
- That a home visit has been conducted to determine the suitability of any requested remediation(s) for the Member.

Asthma Remediation includes providing information to Members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations such as:

1. Identification of environmental triggers commonly found in and around the home, including allergens and irritants.

[20] Asthma Remediation should not interfere with EPSDT benefits. All appropriate EPSDT services should be provided and Community Supports should be complementary. See https://www.hud.gov/sites/dfiles/HH/documents/HUD%20Asthma%20Guide%20Document_Final_7_18.pdf; Appendix B)

2. Using dust-proof mattress and pillow covers, high-efficiency particulate air vacuums, asthma-friendly cleaning products, dehumidifiers, and air filters.

3. Health-related minor home repairs such as pest management or patching holes and cracks through which pests can enter.

The Centers for Disease Control, the Environmental Protection Agency, and Housing and Urban Development collaborated to produce an asthma trigger checklist[21] which MCPs may utilize in determining the appropriateness of these interventions. An accompanying training[22] provides additional details about the connections between asthma triggers and lung health.

Eligibility (Population Subset)

Individuals with poorly controlled asthma (as determined by an emergency department visit or hospitalization or two sick or urgent care visits in the past 12 months or a score of 19 or lower on the Asthma Control Test) for whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

Restrictions/Limitations

- If another State Plan service such as Durable Medical Equipment, is available and would accomplish the same goals of preventing asthma emergencies or hospitalizations.

- Asthma remediations must be conducted in accordance with applicable State and local building codes.

- Asthma remediations are payable up to a total lifetime maximum of $7,500. The only exception to the $7,500 total maximum is if the Member's condition has changed so significantly that additional modifications are necessary to ensure the health, welfare, and safety of the Member, or are necessary to enable the Member to function with greater independence in the home and avoid institutionalization or hospitalization.

- Asthma Remediation modifications are limited to those that are of direct medical orremedial benefit to the Member and exclude adaptations or improvements that are of general utility to the household. Remediations may include finishing (e.g., drywall and painting) to return the home to a habitable condition, but do not include aesthetic embellishments.

[21] https://www.cdc.gov/asthma/pdfs/home_assess_checklist_P.pdf
[22] https://www.epa.gov/sites/production/files/2020-06/home_characteristics_and_asthma_triggers_training_for_home_visitors_0.pptx

- Before commencement of a permanent physical adaptation to the home or installation of equipment in the home, such as installation of an exhaust fan or replacement of moldy drywall, the managed care plan must provide the owner and Member with written documentation that the modifications are permanent, and that the State is not responsible for maintenance or repair of any modification nor for removal of any modification if the Member ceases to reside at the residence. This requirement does not apply to the provision of supplies that are not permanent adaptations or installations, including but not limited to: allergen-impermeable mattress and pillow dust covers; high-efficiency particulate air (HEPA) filtered vacuums; de-humidifiers; portable air filters; and asthma-friendly cleaning products and supplies.

Community supports shall supplement and not supplant services received by the Medi-Cal beneficiary through other State, local, or federally-funded programs, in accordance with the CalAIM STCs and federal and DHCS guidance.

Licensing/Allowable Providers

The Medi-Cal managed care plan may: manage these services directly; coordinate with an existing Medi-Cal provider to manage the services; and/or contract with a county agency, community-based organization or other organization, as needed. The services should be provided in conjunction with culturally appropriate asthma self-management education.

Providers must have experience and expertise with providing these unique services. This list is provided as an example of the types of providers Medi-Cal managed care plans may choose to contract with, but it is not an exhaustive list of providers who may offer the services.

- Lung health organizations
- Healthy housing organizations
- Local health departments
- Community-based providers and organizations

Asthma Remediation that is a physical adaptation to a residence must be performed by an individual holding a California Contractor's License.

- Medi-Cal managed care plans must apply minimum standards to ensure adequate experience and acceptable quality of care standards are maintained. Medi-Cal managed care plans shall monitor the provision of all the services included above.
- All allowable providers must be approved by the managed care organization to ensure adequate experience and appropriate quality of care standards are maintained.

Medi-Cal managed care plan network providers that have a state-level enrollment pathway must enroll in the Medi-Cal program, pursuant to relevant DHCS APLs including Provider Credentialing/Recredentialing and Screening/Enrollment APL 19-004. If there is no state-level enrollment pathway, managed care plans must have a process for vetting the Community Supports Provider, which may extend to individuals employed by or delivering services on behalf of the Community Supports Provider, to ensure it can meet the capabilities and standards required to be a Community Supports Provider.

IV. Community Supports to State Plan Service Crosswalk

Background: The below chart summarizes potential state plan services or settings that each of California's "pre-approved" Community Supports may substitute for. Community Supports may represent an immediate substitute for a State Plan-covered service/setting or a substitute for a State Plan-covered service/setting over a longer timeframe. Additional detail on the cost-effectiveness and medical appropriateness of each service/setting is available in the CA ILOS Evidence Library Executive Summary document posted on the Department's website at: https://www.dhcs.ca.gov/Documents/MCQMD/CA-ILOS-Evidence-Library-Executive-Summary-August-2021.pdf

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
1	**Housing Transition/ Navigation Services**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
2	**Housing Deposits**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
3	**Housing Tenancy and Sustaining Services**	Emergency Department Visit
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Skilled Nursing Facility Services
		Transitional Inpatient Care Services
4	**Short-Term Post-Hospitalization Housing**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Post-Acute care
		Skilled Nursing Facility Services
5	**Recuperative Care (Medical Respite)**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Outpatient Hospital Services
		Post-Acute care
		Skilled Nursing Facility Services
6	**Respite Care**	Home Health Agency
		Home Health Aide
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
7	**Day Habilitation Programs**	Emergency Department Services
		Occupational Therapy
		Outpatient Hospital Services
		Outpatient Mental Health
		Rehabilitation Center Outpatient Services
		Targeted Case Management and Services
8	**Nursing Facility Transition/**	Emergency Department Visit
		Inpatient Services

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
	Diversion to Assisted Living Facility	Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
9	**Community Transition Services/Nursing Facility Transition to Home**	Emergency Department Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Intermediate Care Facility Services for the Developmentally Disabled - Nursing
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
10	**Personal Care and Homemaker Services**	Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Skilled Nursing Facility Stay

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
11	**Environmental Accessibility Adaptations (Home Modifications)**	Emergency Department Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Intermediate Care Facility Services
		Intermediate Care Facility Services for the Developmentally Disabled
		Intermediate Care Facility Services for the Developmentally Disabled Habilitative
		Personal Care Services
		Skilled Nursing Facility Stay
		Specialized Rehabilitative Services in Skilled Nursing Facilities and Intermediate Care Facilities
12	**Medically Tailored Meals/Medically Supportive Foods**	Emergency Department Services
		Emergency Transport Services
		Home Health Agency Services
		Home Health Aide Services
		Inpatient Services
		Outpatient Hospital Services
		Personal Care Services
13	**Sobering Centers**	Emergency Department Services
		Emergency Transport Services
		Inpatient Services
		Emergency Transport Services
14		Asthma-related primary care and specialty visits

#	Community Support (ILOS)	Potential State Plan Service/Setting Substitute
	Asthma Remediation	Emergency Department Services
		Home Health Aide
		Home Health Agency
		Inpatient Stay
		Outpatient Hospital Services
		Personal Care Services

V. Requesting Approval for New Community Supports

MCPs must apply for and obtain State approval prior to offering any new Community Support, and demonstrate that all of the following requirements will be met through the submission of a Community Supports Model of Care:

- Community Supports are voluntary. MCPs cannot require a Member to use a Community Support instead of a State Plan-covered service.
- The alternative services are medically appropriate and cost-effective.
- The population and criteria for the Community Support is clearly defined, and the Community Support will be offered in an equitable and nondiscriminatory manner to eligible Members.
- The MCP has demonstrated capability to calculate the cost-benefit analysis for each Community Support, including tracking and reporting on Community Supports expenditures in a manner and format established by DHCS.
- MCPs must use the HCPCS rate codes through encounter data that have been approved by DHCS to track the claiming and provision of Community Supports.
- Community Supports may not include expenditures prohibited by CMS, such as room and board.

Once DHCS approves an MCP's submitted Community Supports Model of Care, the Community Support must be added to the MCP's contract, subject to federal approval, and will be posted on the DHCS website as a State Approved Community Support. The cost and utilization of the Community Support will be factored into the medical portion of the MCP's rates.

Members always retain the right to file appeals and/or grievances if they request one or more ILOS offered by the MCP, but were not authorized to receive the requested ILOS because of a determination that it was not medically appropriate or cost effective. Community Supports are additionally subject to the State Fair Hearings process. DHCS may terminate an MCP's Community Supports offering if it is determined to be harmful to the Member or is not cost-effective. MCPs may terminate a Community Support upon notice to DHCS once annually at the end of the calendar year, except in cases where the Community Support is terminated due to Member health, safety, or welfare concerns. If an MCP terminates a Community Support, they must publicize the service end date and provide at least 30 days' notice to their Members and implement a plan for continuity of care for Members receiving that Community Support.

See the Community Supports Resource Directory for more information and to access the Model of Care.

VI. Provider Enrollment, Credentialing, and Vetting Requirements

Community Supports Providers as Medi-Cal Enrolled Providers

MCP Network Providers (including those who will operate as Community Supports Providers) are required to enroll as a Medi-Cal Provider if there is a state-level enrollment pathway for them to do so. However, many Community Supports Providers (e.g., housing agencies, medically-tailored meal Providers) may not have a corresponding state-level enrollment pathway and are not required to enroll in the Medi-Cal program. Instead, these Providers must be vetted by the MCP in order to participate as Community Supports Providers.

Process for Medi-Cal enrollment

For those Community Supports Providers with a state-level Medi-Cal enrollment pathway, the Provider would have to enroll through the DHCS Provider Enrollment Division or the MCP can choose to have a separate enrollment process.

Clarifying the Provider "Credentialing" Requirements of APL 19-004

The credentialing requirements articulated in APL 19-004: Provider Credentialing/Recredentialing and Screening/Enrollment only apply to Providers with a state-level pathway for Medi-Cal enrollment. Therefore, Community Supports Providers without a state-level pathway to Medi-Cal enrollment are not required to meet the credentialing requirements in APL 19-004 in order to become "in-network" ECM and/or Community Supports Providers, but must be vetted by the MCP in order to participate.

MCP Requirements Related to Vetting Community Supports Providers Without a State-level Pathway for Medi-Cal Enrollment

To include an Community Supports Provider in their networks when there is no state-level Medi-Cal enrollment pathway, MCPs are required to vet the qualifications of the Provider or Provider organization to ensure they can meet the standards and capabilities required to be an Community Supports Provider. MCPs must submit Policies and Procedures for how they will vet the qualifications of ECM and Community Supports Providers in their Part 2 submission of the MOC. MCPs must create and implement their own processes to do so. Factors MCPs may want to consider as part of their process includes, but are not limited to:

- Ability to receive referrals from MCPs for the authorized Community Supports;
- Sufficient experience to provide services similar to the specific Community Supports for which they are contracted to provide within the service area;
- Ability to submit claims or invoices for Community Supports using standardized protocols;
- Business licensing that meets industry standards;
- Capability to comply with all reporting and oversight requirements;
- History of fraud, waste, and/or abuse;

- Recent history of criminal activity, including a history of criminal activities that endanger Members and/or their families; and
- History of liability claims against the Provider.

VII. Billing & Payments

Community Supports Billing and Invoicing Guidance

DHCS has developed more comprehensive guidance that describes the minimum set of data elements required to be included in an invoice, available from the Community Supports Resource Directory.

Non-Binding Community Supports Pricing Guidance

The Cal-AIM initiative and, in particular, the introduction of the 14 pre-approved health-related Community Supports, prompts MCPs to work and contract with a new set of "non-traditional" Providers that offer services and supports that historically have not been well integrated into the health care system. These Providers include, but are not limited to, housing service Providers, home modification companies, sobering centers, and organizations that prepare and deliver medically-supportive food and nutrition. While many MCPs and Community Supports Providers have some experience working together, particularly in WPC Pilot counties, CalAIM is designed to encourage and support broader contracting and partnerships throughout the State. In recognition that this requires MCPs and Community Supports Providers to engage in new contracting and payment relationships, DHCS has prepared non-binding Community Supports Pricing Guidance. It offers information on potential rates for each of the 14 pre-approved Community Supports, including mid-point benchmarks and a discussion of key cost drivers that MCPs and Community Supports Providers may want to consider as they establish their own contracting and payment arrangements.

Critically, this pricing guidance is designed to serve as a tool to support discussions regarding rates**; it is in no way binding on MCPs or Community Supports Providers**. MCPs and Community Supports Providers have full flexibility and discretion to agree to Community Supports rates that are different than those outlined in this document, particularly because the rates in the pricing guidance are based on data and assumptions that reflect the statewide average cost of inputs. DHCS reserves the right to make modifications to the pricing guidance on an as needed basis based on experience with the Community Supports initiative and its evolution over time.

The Non-Binding Community Supports Pricing Guidance can be accessed from the Community Supports Resource Directory.

Community Supports HCPCS Codes

The ECM and Community Supports Coding Options guidance lists the HCPCS codes that must be used for Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

MCPs must use the HCPCS codes listed in the table to report Community Supports services. The HCPCS code and modifier combined define the service as Community Supports.

DHCS expects MCPs to support their Community Supports Providers in reporting and translating their delivered Community Supports to these required HCPCS codes. While MCPs must use the below HCPCS codes and modifiers for reporting applicable Community Supports encounters to DHCS, MCPs may utilize alternative payment approaches with Community Supports providers. For example, an MCP might opt to pay a provider for Housing Transition and Navigation Services as a per member per month (PMPM) payment. That MCP must still report encounters to DHCS as a per diem for every service rendered by that provider, using the HCPCS codes and modifiers below. **If a Community Support is provided through telehealth, the additional modifier GQ must be used. All telehealth services must be provided in accordance with DHCS policy.**[23]

The Finalized ECM & Community Supports (ILOS) Coding Options can be accessed from the Community Supports Resource Directory.

[23] For more information refer to the DHCS Medi-Cal Provider Manuals

VIII. Consent, Authorization, & Data Sharing

The vision of Community Supports is to embrace and integrate a diversity of Providers in the delivery of whole-person care, and not just traditional health care providers. DHCS acknowledges the tremendous investment required of both MCPs and Provider organizations to realize this from an information technology infrastructure and data sharing perspective. To that end, listed below are high-level data system requirements for MCPs, along with data sharing requirements for MCPs and Community Supports Providers.

Data System Requirements

MCPs are required to have an IT infrastructure and data analytic capabilities to support Community Supports, including the capabilities to:

- Consume and use claims and encounter data, as well as other data types listed in Community Supports Contract Template Section 7: Identifying Members for Community Supports;
- Assign Members to Community Supports Providers;
- Keep records of Members receiving Community Supports and their consent;
- Securely share data with Community Supports Provider;
- Receive, process, and send encounters and invoices from Community Supports Providers to DHCS in accordance with DHCS standards;
- Receive and process supplemental reports from Community Supports Providers;
- Send Community Supports supplemental reports to DHCS; and
- Open, track, and manage referrals to Community Supports Providers.

Data Sharing Requirements for MCPs

In order to support Community Supports, MCPs shall provide, at a minimum, the following information to all Community Supports Providers:

- Physical, behavioral, administrative, and information indicating Member social determinants of health (SDOH) needs, as specified on previously submitted claims encounters or identified through other data sources (e.g., HMIS)[24] for assigned Members; and
- Reports of performance on quality measures and/or metrics, as requested.

MCPs are required to use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

[24] As part of the population health management (PHM) initiative of CalAIM, DHCS has issued guidance encouraging MCPs to incorporate the use of DHCS Priority SDOH Codes; please refer to APL 21-009 for more information.

Data Sharing Requirements for Community Supports Providers

DHCS' vision is that Community Supports Providers will submit encounters to MCPs for transmission to DHCS. Providers that do not have these capabilities will be allowed to submit invoices to MCPs and MCPs will then convert the invoices to encounters for submission to the DHCS.

DHCS is not specifying the payment model between MCPs and Providers for Community Supports, though DHCS encourages plans and Providers to adopt or progress to value based payment (VBP) models for Community Supports.

If the Community Supports Provider is paid by the MCP on a fee-for-service (FFS) basis, they will be expected to generate a claim and send it to the MCP for payment processing. If the Community Supports Provider is unable to send a compliant 837P claim to the MCP, they will be expected to send an invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that they will subsequently submit to DHCS according to current DHCS policy.

If a Community Supports Provider is paid by the MCP on a capitated basis, then the Provider will still be expected to generate and submit a compliant encounter to MCPs. In the event that Community Supports Provider is unable to submit a compliant 837P encounter, they will be expected to send a paid invoice with a minimum set of data elements necessary for the MCP to convert that information into a compliant 837P encounter that the plan will subsequently submit to DHCS according to current DHCS policy.

Community Supports Providers and MCPs may need to re-configure their existing systems to meet these requirements.

Authorization Process

To support Members' access to any offered Community Supports, MCPs must have nondiscriminatory authorization processes in place to determine eligibility for Members for each Community Support, in accordance with the service definitions or other narrower eligibility definitions that have been approved by the Department in advance, in accordance with the MCP's contract with DHCS.

As part of the authorization process, MCPs must document their process for ensuring documentation of appropriate clinical support for the medical appropriateness of the Community Support. This process must detail that provision of the Community Support, recommended by a provider at the plan or network level using their professional judgement, is likely to reduce or prevent the need for acute care or other Medicaid services, including but not limited to inpatient hospitalizations, skilled nursing facility stays, or emergency department visits. Therefore, the Community Support is medically appropriate for that Member.

This process may be incorporated into the MCP's utilization management process, or may include provider-level documentation in an individual's care plan or other record. The service definitions for several Community Supports already require this documentation. For example:

- Recipients of the Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services Community Supports are required to have individualized housing support plans. MCPs may use these plans to document the member needs that qualify them for this service and ensure it is a medically appropriate substitute for State Plan services. Per the service definitions, this documentation could include, for example, documented evidence of a serious chronic condition and/or serious mental illness, and could include a documented risk of institutionalization or requiring residential services because of a substance use disorder.

- When authorizing Asthma Remediation Services, managed care plans are required to provide a written evaluation specific to the member describing how and why the remediation meets the member's needs. MCPs may use these evaluations to document the member needs that qualify them for this service and ensure it is a medically appropriate substitute for State Plan services. Per the service definition, this documentation could include documentation of poorly controlled asthma and documentation from a licensed health care Provider that the service will likely help avoid asthma-related hospitalizations, emergency department visits, or other high-cost services.

In addition to these specific examples, most individuals who receive Community Supports will also qualify for either enhanced care management (ECM) or Complex Case Management (CCM). In these instances, MCPs may use ECM or CCM care plans to document member needs that qualify them for a Community Support and ensure it is a medically appropriate substitute for a State Plan service. This process may apply to any Community Support provided to a recipient who is also in one of these care/case management programs.

MCPs may review requests or referrals for Community Supports services for cost-effectiveness as part of MCPs' utilization management processes during authorization.

Graduation/Deauthorization Process

MCPs must have processes in place for graduating or discontinuing Community Supports for members who no longer qualify for, no longer require, or no longer want to receive Community Supports services. A Notice of Action Letter is required in all situations except for when an eligible member chooses not to participate.

IX. Monitoring, Oversight, and Reporting

Oversight of Community Supports Providers

MCP Requirements

MCPs are required to perform oversight of Community Supports Providers, holding them accountable to all Community Supports requirements contained in the ECM and Community Supports Contract Template, the MCP's MOC, and any associated guidance issued by DHCS. MCPs are expected to use Community Supports Provider Standard Terms and Conditions to develop Community Supports contracts with Community Supports Providers, and are expected to incorporate all Community Supports Provider requirements reviewed and approved by DHCS as part of its MOC, including all monitoring and reporting criteria. To streamline the Community Supports implementation:

- MCPs must hold Community Supports Providers responsible for the same reporting requirements as those that the MCP must report to DHCS.
- The MCPs will not impose mandatory reporting requirements that differ from or are additional to those required for encounter and supplemental reporting; and
- MCPs are encouraged to collaborate with other MCPs within the same county on oversight of Community Supports Providers.

Subcontractors

MCPs may subcontract with other entities to administer Community Supports, provided they adhere to the below requirements:

- MCPs will maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, regardless of the number of layers of subcontracting;
- MCPs will be responsible for developing and maintaining DHCS approved Policies and Procedures to ensure Subcontractors meet required responsibilities and functions;
- MCPs will be responsible for evaluating the prospective Subcontractor's ability to perform services;
- MCPs will remain responsible for ensuring the Subcontractor's Community Supports Provider capacity is sufficient to serve eligible Members;
- MCPs will report to DHCS the names of all Subcontractors by Subcontractor type and service(s) provided, and identify the county or Counties in which Members are served; and
- MCPs will make all Subcontractor agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation.

MCPs will ensure their agreements with any Subcontractor mirrors the requirements set forth in ECM and Community Supports Contract Template, and the ECM and Community Supports Provider Standard Terms and Conditions, as applicable to Subcontractor. MCPs are encouraged to collaborate with their Subcontractors on the approach to Community Supports to minimize variance in how Community Supports will be implemented and to ensure a streamlined, seamless experience for Community Supports Providers and Members.

Model of Care (MOC) and Approval Process

The ECM and Community Supports MOC is each MCP's framework for providing ECM and Community Supports. Each MCP's MOC will include its overall approach to ECM and Community Supports; its detailed Policies and Procedures with regard to ECM and Community Supports Provider (including non-traditional Providers) contracting and oversight; its ECM and Community Supports Provider network capacity; and the contract language that will define key aspects of its arrangements with its ECM and Community Supports Providers. The MOC also includes specific "Transition and Coordination" content for MCPs operating in Whole Person Care (WPC) and/or Health Home Program (HHP) Counties. MCPs in these Counties must describe how they will ensure smooth transitions for their Members from WPC and HHP into ECM and Community Supports.

DHCS will use each MCP's MOC submission to determine its readiness to meet ECM and Community Supports requirements. MCPs must lay out their MOCs using the DHCS-developed standard template (MOC Template) and submit them to DHCS for review and approval prior to initial ECM and Community Supports implementation in 2022. MCPs must make updates to their MOCs to reflect any Community Supports changes.

MCPs should expect review of the MOC to be an iterative process with DHCS during each review period. DHCS may require resubmission of certain questions or additional material to ensure alignment with DHCS requirements.

Encounter Data Submission Process

DHCS requires MCPs to submit encounter data in accordance with requirements in the MCP contract and All Plan Letter 14-019, or any subsequent updates. MCPs are required to submit encounter data for Community Supports through the existing encounter data reporting mechanisms for all covered services for which they have incurred any financial liability, whether directly or through subcontracts or other arrangements, using ASC X12 837 version 5010 x223 Institutional and Professional transactions or NCPDP 2.2 or 4.2 transactions and the new Community Supports coding requirements, to the Post Adjudicated Claims and Encounters System (PACES) beginning on January 1, 2022.

Scope of Monitoring Activities

DHCS will monitor MCPs implementation of and compliance with ECM and Community Supports requirements across multiple domains including, Membership, Service Provision, Grievances and Appeals, Provider Capacity, and Quality. DHCS will monitor MCP compliance with ECM and Community Supports using existing monitoring processes as well as through submission of time-limited quarterly Implementation Monitoring Report Templates.

X. Performance Incentive Program

CalAIM's ECM and Community Supports programs will require significant new investments in care management capabilities, Community Supports infrastructure, information technology (IT) and data exchange, and workforce capacity at both the MCP and Provider levels. Incentive payments will be a critical component of CalAIM to promote MCP and Provider participation in, and capacity building for, ECM and Community Supports.

DHCS has designed an incentive payment approach with input from stakeholders with the goal of issuing initial payments to MCPs beginning in January 2022 for the achievement of defined milestones. Infrastructure development, ECM and Community Supports Provider capacity building, and Community Supports take-up are priority areas for Program Year 1 (i.e., Calendar Year 2022). DHCS will incorporate behavioral and physical health integration and health disparities reduction measures within those priority areas. Quality will emerge as a priority area for Program Year 2 (i.e., Calendar Year 2023).

Additional guidance on the Performance Incentive Program, as well more details on available Projects for Assistance in Transition from Homelessness (PATH) Funding, is available on the ECM & Community Supports webpage.

Listed below are the goals and design principles of the program.

Performance Incentive Goals:

- Build appropriate and sustainable ECM and Community Supports capacity
- Drive MCP investment in necessary delivery system infrastructure
- Incentivize MCP take-up of Community Supports
- Bridge current silos across physical and behavioral health delivery
- Reduce health disparities and promote health equity
- Achieve improvements in quality performance

Performance Incentive Design Principles:

1. Develop a clear incentive payment allocation methodology where all plans have an opportunity to participate equitably
2. Set ambitious, yet achievable measure targets
3. Ensure efficient and effective use of all performance incentive dollars
4. Drive significant investments in core priority areas up front
5. Minimize administrative complexity
6. Address variation in existing infrastructure and capacity between Whole Person Care (WPC) / Health Home Program (HHP) Counties and non-WPC/HHP Counties
7. Ensure use of incentive dollars does not overlap with other DHCS incentive programs or with services funded through the rates
8. Measure and report on the impact of incentive funds

XI. Community Supports Resource Directory

Community Supports Resource Directory	
Resource	**Description**
ECM and Community Supports (ILOS) Website	Online repository for ECM & Community Supports (ILOS) program documents and technical assistance. Future guidance will be posted here.
Community Supports Fact Sheet	Overview of Community Supports and DHCS' vision for the Community Supports initiative
Frequently Asked Questions Document	Answers to key Community Supports policy questions. Document will updated with new questions/answers on an ad hoc basis
ECM & Community Supports Change Memo	Summary of key policy changes DHCS made to ECM and Community Supports requirements documents based on stakeholder feedback.
DHCS-MCP ECM and Community Supports (ILOS) Contract Template	Community Supports contract requirements for MCPs.
ECM and Community Supports (ILOS) Standard Provider Terms and Conditions	Standardized language that MCPs must include in all contracts with Community Supports Providers.

CalAIM ECM and Community Supports Model of Care Cover Note: Instructions and Timeline **CalAIM ECM and Community Supports (ILOS) Model of Care Template**	Template for MCP to outline proposed protocols for implementation and provision of Community Supports. Each MOC must be reviewed and approved by DHCS prior to Community Supports implementation.
ECM and Community Supports (ILOS) Coding Guidance	Guidance on encounter data submissions and a list of HCPCS Level II Codes for Community Supports services delivered.
Community Supports (ILOS) Evidence Library – Executive Summary	Select highlights and key findings of DHCS' research on the measurable impacts Community Supports may have on health care costs, utilization, and health outcomes
Non-Binding Community Supports Pricing Guidance*	Non-Binding guidance on pricing for Community Supports services.
Community Supports Billing & Invoicing Guidance*	Guidance defining the standard, "minimum necessary" data elements MCPs will collect from Community Supports Providers.
Community Supports Quarterly Implementation Reporting Framework*	Guidance defining DHCS' strategy for monitoring the implementation of Community Supports.

*Check the ECM and Community Supports (ILOS) Website for the latest updates and versions of Community Supports documents.

XII. Glossary of Terms

Medicaid Section 1115 Demonstration Waivers: Section 1115 wavers permit States to use federal Medicaid funds in ways that are not otherwise allowed under federal rules, as long as the U.S. Secretary of Health and Human Services determines that the initiative isan "experimental, pilot, or demonstration project" that is "likely to assist in promoting the objectives of the program." Section 1115 waivers are generally approved for a five-year period.

Section 1915(b) "Freedom of Choice" waivers: States generally use section 1915(b) waivers to require enrollment in managed care delivery systems for certain populations. Many States originally used Section 1115 waiver authority to move enrollees intomanaged care, but the new federal regulations acknowledge that managed care is now the predominant delivery system in Medicaid and CMS has indicated that Section 1115 waivers may not be the most appropriate authority vehicle for managed care.

Section 1915(c) "Home and Community Based Services" waivers: States generally use 1915(c) waivers to develop programs that meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting.

Behavioral Health: Mental health and substance use disorder services.

Behavioral Health Managed Care Plan: The county prepaid inpatient health plan (PIHP) that would provide specialty mental health services and SUD treatment services under a single contract with DHCS, after full implementation of the behavioral health integration proposal.

CalAIM: California Advancing and Innovating Medi-Cal: DHCS' multi-year initiative to implement overarching policy changes across all Medi-Cal delivery systems with the following objectives:

- Identify and manage member risk and need through Whole Person Care Approaches and addressing Social Determinants of Health;
- Move Medi-Cal to a more consistent and seamless system by reducing complexityand increasing flexibility; and
- Improve quality outcomes, reduce health disparities, and drive delivery system transformation and innovation through value-based initiatives, modernization of systems, and payment reform.

Coordinated Care Initiative (CCI): CCI was implemented in 2014 in seven California counties with the goal of coordinating the delivery of medical, behavioral, and long-term

services and supports to Medi-Cal beneficiaries also eligible for Medicare ("dual eligibles"). The CCI is composed of Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS). The Cal MediConnect portion of CCI is currently authorized through December 31, 2022.

County Inmate Pre-Release Application Process: A CalAIM proposal that all counties must implement an inmate pre-release Medi-Cal application process to ensure that county inmates/juveniles who are eligible for Medi-Cal and are in need of ongoing physical or behavioral health treatment receive timely access to services upon release from incarceration. The proposed process would require all county jails and juvenile facilities to implement a process for facilitated referral and linkage from county jail release to specialty mental health, Drug Medi-Cal, DMC-ODS and Medi-Cal managed care providers, in cases where the inmate was receiving behavioral health services while incarcerated, to allow for continuation of behavioral health treatment in the community.

County Organized Health System (COHS): A local agency created by a county board of supervisors to contract with the Medi-Cal program. Nearly all Medi-Cal beneficiaries ina COHS county receive their care from the COHS health plan.

Cal MediConnect: A program that coordinates medical, behavioral, and long-term services and supports (i.e. both Medicare and Medi-Cal benefits) for dual eligibles in seven California CCI counties.

Community Supports (In lieu of services): Services offered by a Medi-Cal health plan that are not included in the State Plan, but are medically appropriate, cost-effective substitutes for State Plan services included within the contract. Applicable in lieu of services must be specifically included in a managed care plan's contract. Services are offered at the plan's option and a Member cannot be required to use them.

Dental Transformation Initiative (DTI): The DTI is a component of the Medi-Cal 2020 demonstration that aims to increase the use of preventive dental services for children, prevent and treat more early childhood caries, and increase continuity of care for children.

Designated Public Hospitals: A California hospital operated by a county, a city and a county, or the University of California.

Designated State Health Programs: Designated State Health Programs (DSHPs) are existing State-funded health programs that have not previously qualified for federal funding, including Medicaid. CMS released a State Medicaid Director Letter informing States that they would phase-out federal funding for DSHPs beginning in 2017, meaning that California's DSHPs will not receive federal funding past December 31, 2020 when the Medi-Cal 2020 demonstration expires.

Drug Medi-Cal: Drug Medi-Cal pays for the SUD treatment services a Medi-Cal beneficiary receives through a Drug Medi-Cal certified program.

Drug Medi-Cal Organized Delivery System (DMC-ODS): DMC-ODS is a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services. The program enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. These systems are currently operating in 30 California counties. This program was initially authorized in during the 2010 Bridge to Reform demonstration and was reauthorized in the current Medi-Cal 2020 demonstration.

Enhanced Care Management: A collaborative and interdisciplinary benefit to provide intensive and comprehensive ('whole-person') care management services to high-need Medi-Cal beneficiaries.

Full Integration Plan: A CalAIM proposal to consolidate multiple Medi-Cal delivery systems (Medi-Cal managed care, mental health managed care, DMC-ODS, and dental) under one contract with DHCS. This proposal would only be implemented in select areas with managed care plans and corresponding counties who have mutually volunteered to participate.

Global Payment Program (GPP): Established a statewide pool of funding for the remaining uninsured by combining federal disproportional share hospital and uncompensated care funding, where select Designated Public Hospital systems can achieve their "global budget" by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventive services. GPP is currently set to expire on December 31, 2020 and with approval pending under the Medi-Cal 2020 Demonstration extension to continue for calendar year 2021.

Health Homes Program: Enables participating health plans to provide a range of supports to Med-Cal beneficiaries with complex medical needs and chronic conditions. The HHP includes coordination of the full range of physical health, behavioral health, andcommunity-based long-term services and supports.

Indian Health Care Providers: Means a health care program operated by the Indian Health Service or by an Indian Tribe, Tribal Organization, or Urban Indian Organization per 42 CFR §438.14(a).

Institution for Mental Diseases (IMD): A hospital, nursing facility, or other institution with more than sixteen beds that is primarily engaged in providing diagnosis, treatment, or care to persons with mental diseases (42 U.S.C. §1396d(i)).

Long Term Care: Included skilled nursing facilities, subacute facilities, pediatric subacute facilities, and intermediate care facilities.

Long Term Service and Supports: Services that include medical and non-medical carefor people with a chronic illness or disability. Long-term care services are those provided to an individual who requires a level of care equivalent to that received in a nursing facility. Most long-term care services assist people with Activities of Daily Living, suchas dressing, bathing, and using the bathroom. Long-term care can be provided at home, in the community, or in a facility.

Managed Long Term Services and Supports (MLTSS) Program: The delivery of long-term services and supports through capitated Medi-Cal managed care programs.

Medi-Cal 2020: California's current Section 1115 waiver that expires on December 31, 2020. Medi-Cal 2020 authorized the Whole Person Care program, Global Payment Program, the Public Hospital Redesign and Incentives in Medi-Cal (PRIME) Program, Dental Transformation Initiative, and extended several other California waiver programs including the Drug Medi-Cal Organized Delivery System.

Medi-Cal Managed Care Plan: A health plan that has a contract with DHCS to deliver most physical health care and mild-to-moderate mental health care services to Medicaid beneficiaries through a network of providers at a capitated rate. Managed care plans emphasize primary and preventive care.

Mental Health Managed Care Plan: A health plan that has a contract with DHCS to provide specialty mental health services to Medi-Cal beneficiaries. Mental health managed care plans in California are administered by the counties.

National Committee for Quality Assurance (NCQA): A health care accreditation organization with a focus on improving health care quality.

Population Health Management Program: A cohesive plan of action for addressing member needs across the continuum of care, based on data-driven risk stratification, predictive analytics, and standardized assessment processes. Each Medi-Cal managed care plan will provide DHCS with a strategy for how it will:

- Keep all members healthy by focusing on preventive and wellness services;
- Identify and assess member risks and needs on an ongoing basis;
- Manage member safety and outcomes during transitions, across delivery systems or settings, through effective care coordination; and
- Identify and mitigate the social determinants of health and reduce health disparities or inequities.

Public Hospital Redesign and Incentives in Medi-Cal (PRIME): An incentive program for Designated Public Hospitals and District and Municipal Public Hospitals designed to improve their delivery systems through a focus on providing high quality, value-based care. PRIME is the successor program to the first-in-the-nation DSRIP (Delivery System Reform Incentive Payment) program that was authorized in the Bridge to Reform demonstration in 2010. PRIME funding is authorized under the Medi-Cal 2020 demonstration and expired on June 30, 2020.

Quality Incentive Program (QIP): The QIP ties Medi-Cal managed care payments to performance on designated performance metrics in four strategic categories: primary care, specialty care, inpatient care, and resource utilization. The payments are linked to delivery of services under Medi-Cal managed care contracts and increase the amount of funding tied to quality outcomes. California's Designated Public Hospitals receive incentive payments based on achievement of specified improvement targets. Under CalAIM, the District and Municipal Public Hospitals started to participate in the QIP once PRIME expired.

Regional Rates: A CalAIM proposal to develop regional managed care capitation rates, rather than plan- and county-based rates, in order to simplify the rate-setting process for the Medi-Cal program and allow for more capacity to implement outcomes and value based payment structures.

Safety Net Care Pools (SNCPs): Federal Medicaid funding for safety net providers' uncompensated care costs associated with Medicaid eligible and uninsured individuals. California had SNCPs in the Section 1115 demonstrations that began in 2005 and in 2010. This funding transitioned to be a component of the Global Payment Program in the Medi-Cal 2020 demonstration.

Serious Mental Illness/Seriously Emotional Disturbance Demonstration Opportunity: A federal opportunity for States to receive federal Medicaid funding for short-term residential treatment services in settings otherwise subject to the institution for mental disease (IMD) exclusion. (See SMD #18-011)

Social Determinants of Health: Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks (Healthy People 2020).

Targeted Case Management: Targeted Case Management (TCM) is a Medi-Cal program that provides specialized case management services to certain Medi-Cal eligible individuals to gain access to needed medical, social, educational, and other services. The TCM Program is an optional Medi-Cal Program operated with federal and local funds. Eligible populations include:

- Children under age 21;

- Medically fragile individuals;
- Individuals at risk of institutionalization;
- Individuals in jeopardy of negative health or psycho-social outcomes; and
- Individuals with a communicable disease.

Whole Person Care: A pilot program that provides approved counties with funding to coordinate health, behavioral health, and social services for Medi-Cal beneficiaries. The program is authorized under the Medi-Cal 2020 demonstration and expires on December31, 2020, with approval pending to extend through calendar year 2021.

From:	Regulatory Affairs
To:	Business Integration
Cc:	Herman, Mike; Kilgust, Andrew; Phillips, Annie; Tungol, Cesar; Cardenas, Albert; Bamberg2, Jennifer; Myers, Shelly; Shook, Mike; Robinson, Scott; Petrillo, Sloane; Jones, Pshyra; Rex-Kimmet, Kelly; Klipfel, Kelly; Rustad, Eric; Onishi, Nora; Laase, Melanie; Tse, Andrew; Ku, Joanne; Reyes, Jhonathan; Cabral, Rick; Giardina, Kelly; Jeannis, Marie; Laughlin, Michelle; Bogdan, Jill; Huang, Nancy; Rizzuto, Janis; Wood, Michael; Domicolo, Monica; Vaughn, Annabel; Nguyen, Tunhi Jenny; Frias, Patricia; Herrera, Monica; Frankle, Patrick; Selleck, Rachel; Hui, Ravina; Gaur, Poorva; Huerta, Danah; Dao, Kristopher; Schulz, Amanda; De Sarkar, Chumki; Higbee, Donovan; Mark, Jackie; Matthews, Angela; Yeo, Junna; Magee, Claudia; Choo, Marsha; RAC Medi-Cal; RAC Policies; Selleck, Rachel; Mark, Jackie; Higbee, Donovan; Hill, Jared
Subject:	[Medi-Cal]: CalAIM: Updated ECM Guidance: Authorization Process and Continuity of Care Requirements (COC) for ECM
Date:	Monday, January 3, 2022 8:14:00 AM

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M E M O R A N D U M

To:	Business Integration
Copy:	CalAIM Workgroup, Government Affairs, and Regulatory Affairs & Compliance
From:	Mike Wood, Regulatory Affairs & Compliance
Date:	January 3, 2022
Subject:	[Medi-Cal]: CalAIM: Updated ECM Guidance: Authorization Process and Continuity of Care Requirements (COC) for ECM

Summary

On 12/31/21, the Department of Health Care Services (DHCS) provided guidance to the managed care plans related to members who receive Enhanced Care Management (ECM) and change their plan selection/enrollment as outlined below.

Continuity of Care (COC) Requirements:

1. Continuity of Care (COC) requirements, which mandate continuity with the previous provider for specific covered services, do not apply to the new Enhanced Care Management (ECM) benefit.

ECM Authorization Requirements

2. To ensure the most high-need Medi-Cal Members previously identified as ECM-eligible and were receiving ECM are able to maintain gains due to ECM, DHCS will consider Members receiving ECM in a previous plan to be ECM-eligible upon enrollment in a new plan. Therefore, MCPs must automatically authorize ECM eligibility for such Members in the new plan.
    a. MCPs may receive requests directly from the Member, the Member's family or authorized representative (AR) requesting ECM. Upon Member request and attestation, MCPs must automatically authorize such Member requests and reassess Members based on their ECM discontinuation criteria.
        i. MCPs should work with the previous MCP, the Member or ECM Provider to obtain access to the Member's Care Management Plan to mitigate any gaps in care.
        ii. MCPs must follow their Policy and Procedures (P&Ps) for assigning Members to ECM Providers and take steps to re-assess Members based on their discontinuation criteria.
    b. MCPs will receive ECM encounter data as part of the 12-month historical utilization data set under the Plan Data Feed. MCPs should assign any "new" ECM Members who have historical ECM service utilization within the prior 90 days using their standard ECM outreach and engagement process.
        i. The presence of ECM service HCPCS codes contained within the prior 90 days of historical utilization data the MCP receives is sufficient to add the Member to the MCP's existing ECM outreach and engagement process, and assign to an ECM Provider.
        ii. MCPs are expected to initiate their ECM assignment process with Members that are identified through this process as soon as they become aware of this information.

Pursuant to AB 133, W&IC section 14184.102(d), DHCS has the authority to interpret and implement CalAIM through APLs, information notices, and similar instructions. As such, DHCS will formally add this as a required response in the Model of Care (MOC) and update the ECM Policy Guide to include this guidance.

DHCS will release an updated Model of Care (MOC) that will include a new question requesting ECM P&Ps reflecting the above authorization policy for ECM Members who change plans. Please note, the request to update ECM P&Ps will not go above and beyond the requirements outlined in this communication.

MCPs will be required to update their ECM MOC to include this requirement in their **MOC P&Ps by February 15, 2022**. MCPs must come into compliance with this requirement no later than March 1, 2022.

Impact / Affected Business Area(s)

The Regulatory Affairs & Compliance (RAC) department has conducted a preliminary impact analysis, and what follows below are suggested impacts based on RAC's initial review. Business Integration (BI) will coordinate with impacted departments to facilitate the implementation efforts related to the guidance, including a comprehensive review of the information in its entirety and determining appropriate next steps.

Action(s)

Back to Item Back to Agenda

Will BI please coordinate with impacted departments / teams to facilitate CalOptima's implementation efforts related to this guidance, as appropriate?

Potential actions/next steps may include:

- Updated ECM MOC:
  - Upon distribution from DHCS, please update CalOptima's ECM MOC to include the requirements outlined above in CalOptima's impacted P&Ps and submit to RAC by **COB, Friday, February 11, 2022** (CalAIM Workgroup).
    - RAC will submit the revised ECM MOC and revised P&Ps to DHCS no later than Tuesday, February 15, 2022.

Next Step(s)

Please work with BI as you plan for and/or implement this guidance in your department. BI will provide any required action items to RAC by the identified deadline, as necessary, on behalf of the impacted departments.

Please feel free to contact Mike Wood or Monica Domicolo with any questions about the regulatory guidance.

**If you can't access the documents linked to in this memo, open an eTicket and request access to G:\Regulatory Library.*

Model of Care (MOC) Amendment due by December 15

All MCPs must have a documented process on file with DHCS and submit answers to the amended questions below by **December 15**, unless their MOC submission already covered these elements in full. DHCS is confirming with those MCPs individually and that they do not need to provide an MOC amendment.

DHCS expects MCPs to have engaged in transition discussions with WPC Lead Entities to obtain this information if they have not already done so.

1) Please indicate that the MCP has engaged in transition conversations regarding the justice-involved Population of Focus and confirm that the MCP is automatically transitioning to ECM on 1/1/22 all those identified to transition, including (as applicable) justice-involved individuals.

   CalOptima response: CalOptima will contract with the Orange County Health Care Agency (OC HCA aka WPC Lead Entity for Orange County) to continue to provide ECM services as an ECM Provider for this Population of Focus, which will enable CalOptima to leverage all existing services to ensure a smooth transition as of January 1, 2022.

2) Describe how the MCP will maintain the infrastructure developed under WPC to serve its members who meet the ECM justice-involved Population of Focus beyond the group that automatically transitioned into ECM on 1/1/22. Include in this description:

   a. The process the MCP will use to receive and act on external referrals via existing WPC infrastructure.

      CalOptima response: CalOptima and OC HCA have agreed to continue to utilize the WPC Connect system built through the WPC Pilot to ensure those data exchange and referral streams are maintained. Also, CalOptima will work with OC HCA to ensure any currently utilized WPC Pilot referral streams, specifically through OC HCA's Correctional Health Services department, continue and are integrated into the new ECM and Community Supports referral processes as of 1/1/22. Furthermore, CalOptima will ensure the new ECM referral forms are updated to specifically include the justice-involved Population of Focus criteria which will create a new referral pathway for this population.

   b. The process the MCP will use to assign the justice-involved population to ECM Providers.

      CalOptima response: CalOptima and its delegated health networks will authorize and assign members in the justice-involved Population of Focus to OC HCA to begin providing ECM services to the member.

18. Contractor's Responsibility for Administration of Community Supports

A. Contractor may provide DHCS pre-approved Community Supports as described in Provision 19, DHCS Pre-Approved Community Supports of this Attachment.

The remainder of Exhibit A, Attachment 22 refers only to Community Supports that Contractor may choose to offer, unless otherwise specified.

B. In accordance with 42 CFR section 438.3(e)(2), all applicable APLs, and the Community Supports Policy Guide, Contractor may select and offer Community Supports from the list of Community Supports pre-approved by DHCS as medically appropriate and cost-effective substitutes for Covered Services or settings under the State Plan. See Provision 19, DHCS Pre-Approved Community Supports below for list.

1) Contractor must ensure medically appropriate State Plan services are available to the Member regardless of whether the Member has been offered a Community Supports, is currently receiving a Community Supports, or has received a Community Supports in the past.

2) Contractor may not require a Member to utilize a Community Supports. Members always retain their right to receive the California Medicaid State Plan Covered Services on the same terms as would apply if a Community Supports was not an option in accordance with regulatory requirements.

3) Contractor must not use Community Supports to reduce, discourage, or jeopardize Members' access to State Plan services.

4) Contractor may submit a request to DHCS to offer Community Supports in addition to the pre-approved Community Supports.

C. With respect to pre-approved Community Supports, Contractor must adhere to DHCS' guidance on service definitions, eligible populations, code sets, potential Community Supports Providers, and parameters for each

Community Supports, referenced in APL 21-017 and the Community Supports Policy Guide, that Contractor chooses to provide. Upon approval from DHCS, Contractor may adopt a more narrowly defined eligible population than outlined in the Community Supports Policy Guide.

1) Contractor is not permitted to extend a Community Supports to Members beyond those for whom DHCS has determined the Community Supports will be cost-effective and medically appropriate, as indicated in the DHCS guidance on eligible populations.

2) Contractor must provide public notice of any limitations on Community Supports when Contractor requests an alternate approach involving narrowing eligible populations, including specifying such limitations in the Member Services Guide/EOC and on Contractor's website, in addition to receiving DHCS' written approval.

D. If Contractor elects to offer one (1) or more pre-approved Community Supports, it need not offer the Community Supports in each county it serves. Contractor must report to DHCS the counties in which it intends to offer the Community Supports. Contractor must provide Community Supports in a county selected by Contractor in accordance with the requirements set forth below in Provision 21, Community Supports Provider Capacity.

E. Contractor must identify Members who may benefit from Community Supports and for whom Community Supports will be a medically appropriate and cost-effective substitute for Covered Services, and accept requests for Community Supports from Members and Members' Providers and organizations that serve them, including community-based organizations as described below in Provision 23, Identifying Members for Community Supports.

F. Contractor must authorize Community Supports for Members deemed eligible in accordance below with Provision 24, Authorizing Members for Community Supports and Communication of Authorization Status.

G. Contractor may elect to offer value-added services in addition to offering one (1) or more Community Supports. Offering Community Supports does not preclude Contractor from

offering value-added services.

H. In the event of any discontinuation of Community Supports resulting in a change in the availability of services, Contractor must adhere to the requirements set forth in Exhibit A, Attachment 9, Provision 10, Changes in Availability or Location of Covered Services, and Exhibit A, Attachment 13, Provision 4, Notification of Changes in Access to Covered Services.

I. When Members are dually eligible for Medicare and Medi-Cal, and enrolled in a Medicare Advantage Plan, including a D-SNP, Contractor must coordinate with the Medicare Advantage Plan in the provision of Community Supports.

J. Contractor must not require Members to use Community Supports.

19. DHCS Pre-Approved Community Supports

A. Contractor may choose to offer Members one (1) or more of the following pre-approved Community Supports, and any subsequent Community Supports additions pre-approved by DHCS, in each county:

1) Housing Transition Navigation Services;

2) Housing Deposits;

3) Housing Tenancy and Sustaining Services;

4) Short-Term Post-Hospitalization Housing;

5) Recuperative Care (Medical Respite);

6) Respite Services;

7) Day Habilitation Programs;

8) Nursing Facility Transition/Diversion to Assisted Living Facilities;

9) Community Transition Services/Nursing Facility Transition to a Home;

10) Personal Care and Homemaker Services;

11) Environmental Accessibility Adaptations;

12) Medically Tailored Meals/Medically Supportive Food;

13) Sobering Centers; and

14) Asthma Remediation.

B. Contractor must list all Community Supports it offers in its Contractor's Community Supports MOC template and Community Supports MOC amendments.

C. Contractor must ensure Community Supports are provided in accordance with all applicable APLs, unless DHCS has provided written approval of an alternate approach requested by Contractor.

D. Contractor must ensure Community Supports are provided to Members in a timely manner, and must develop policies and procedures outlining its approach to managing Community Supports Provider shortages or other barriers to ensure timely provision of Community Supports.

E. Contractor may discontinue offering Community Supports annually with notice to DHCS at least 90 calendar days prior to the discontinuation date.

Contractor must ensure Community Supports that were authorized for a Member prior to the discontinuation of those specific Community Supports are not disrupted by a change in Community Supports offerings, either by completing the authorized service or by seamlessly transitioning the Member into other Medically Necessary services or programs that meet the Member's needs.

F. At least 30 calendar days before discontinuing Community Supports, Contractor must notify Members affected by the discontinuation of the Community Supports of the following:

1) The change and timing of discontinuation, and

2) The procedures that will be used to ensure completion of the authorized Community Supports or a transition

into other comparable Medically Necessary services.

G. Contractor may provide voluntary services that are neither State-approved Community Supports nor Covered Services when medically appropriate for the Member, in accordance with 42 CFR section 438.3(e)(1). Such voluntary services are not subject to the terms of Provision 18, Contractor's Responsibility for Administration of Community Supports, through Provision 31, Community Supports Quality and Performance Incentive Program, and are subject to the limitations of 42 CFR section 438.3(e)(1).

20. Community Supports Providers

A. Community Supports Providers are entities that Contractor has determined can provide the Community Supports to eligible Members in an effective manner consistent with culturally and linguistically appropriate care, as outlined in Exhibit A, Attachment 9, Provision 13, Cultural and Linguistic Program.

B. Contractor must enter into Subcontractor Agreements with Community Supports Providers for the delivery of elected Community Supports elected by Contactor.

C. Contractor must ensure all Community Supports Providers for whom a State-level enrollment pathway exists enroll in Medi-Cal, pursuant to relevant APLs, including APL 19-004. If APL 19-004 does not apply to a Community Supports Provider, Contractor must have a process for verifying qualifications and experience of Community Supports Providers, which must extend to individuals employed by or delivering services on behalf of the Community Supports Provider. Contractor must ensure that all Community Supports Providers meet the capabilities and standards required to be a Community Supports Provider.

D. In accordance with Provision 26 below, Data System Requirements and Data Sharing to Support Community Supports, Contractor must support Community Supports Provider access to systems and processes allowing them to do the following, at a minimum:

1) Obtain and document Member information including eligibility, Community Supports authorization status,

Member authorization for data sharing to the extent required by law, and other relevant demographic and administrative information; and

2) Contractor must also support Community Supports Provider notification to Contractor and ECM Providers and Member's PCP, as applicable, when a referral has been fulfilled, as described below in Provision 26, Data System Requirements and Data Sharing to Support Community Supports.

D. To the extent Contractor elects to offer Community Supports, Contractor may coordinate its approach with other Medi-Cal Managed Care Health Plans offering Community Supports in the same county.

21. Community Supports Provider Capacity

A. Contractor must develop a robust network of Community Supports Providers to deliver all elected Community Supports.

B. If Contractor is unable to offer its elected Community Supports to all eligible Members for whom it is medically appropriate and cost-effective within a particular county, Contractor must submit ongoing progress reports to DHCS in a format and manner specified by DHCS.

C. Contractor must ensure its contracted Community Supports Providers have sufficient capacity to receive referrals for Community Supports and provide the agreed-upon volume of Community Supports to Members who are authorized for such services on an ongoing basis.

22. Community Supports MOC

A. Contractor must develop a Community Supports MOC in accordance with the DHCS-approved Community Supports MOC template. The Community Supports MOC must specify Contractor's framework for providing Community Supports, including a listing of its Community Supports Providers and policies and procedures for partnering with Community Supports Providers for the provision of Community Supports.

B. In developing and executing Subcontractor Agreements with Community Supports Providers, Contractor must incorporate

all requirements and policies and procedures described in its Community Supports MOC, in addition to all applicable APLs.

C. Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county, on the development of its Community Supports MOC.

D. Contractor must submit its Community Supports MOC for DHCS review and approval. Contractor must submit to DHCS any Significant Changes to its Community Supports MOC for DHCS review and approval at least 60 calendar days in advance of any occurrence of changes or updates, in accordance with DHCS policies and guidance, including all applicable APLs. Significant Changes may include, but are not limited to, changes to Contractor's approach to administer or deliver Community Supports services, approved policies and procedures, and Subcontractor Agreement boilerplates.

23. Identifying Members for Community Supports

A. Contractor must utilize a variety of methods to identify Members who may benefit from Community Supports, in accordance with all applicable APLs.

B. Contractor must develop policies and procedures for Community Supports, an submit its policies and procedures to DHCS for review and approval prior to its implementation. Contractor's policies and procedures must address the following, at a minimum:

1) How Contractor will identify Members eligible for Community Supports;

2) How Contractor will notify Members; and

3) How Contractor will accept requests for Community Supports from Providers, other community-based entities, and Member or Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons.

C. Contractor must submit all Member notices to DHCS for review and approval prior to implementation.

D. Contractor must ensure that Member identification methods

for Community Supports are equitable and do not exacerbate or contribute to existing racial and ethnic disparities.

E. Transition of WPC and HHP to Community Supports

1) In HHP and WPC pilot counties, Contractor may offer Community Supports to HHP and WPC Members who receive similar services through WPC or HHP for continuity of the services being delivered as part of those programs.

2) In HHP and WPC pilot counties, Contractor must enter into Subcontractor Agreements with all WPC Lead Entities and HHP CB-CMEs as Community Supports Providers, regardless of whether Contractor offers Community Supports on a county-wide basis, unless Contractor receives prior written approval from DHCS, through the Community Supports MOC review process, based on one (1) or more of the following exceptions:

a) The Community Supports Provider does not provide the Community Supports that Contractor elected to offer;

b) There is a justified quality of care concern with the Community Supports Provider;

c) Contractor and the Community Supports Provider are unable to agree on contracted rates;

d) The Community Supports Provider is unwilling to enter into a Subcontractor Agreement;

e) The Community Supports Provider is unresponsive to multiple attempts to enter into a Subcontractor Agreement;

f) The Community Supports Provider is unable to comply with the Medi-Cal enrollment process or vetting by Contractor; or

g) The Community Supports Provider without a State-level pathway to Medi-Cal enrollment is unable to comply with Contractor's processes for vetting qualifications and experience.

24. Authorizing Members for Community Supports and Communication of Authorization Status

A. Contractor must develop policies and procedures that explain how Contractor will authorize Community Supports for eligible Members in an equitable and non-discriminatory manner. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.

B. Contractor must monitor and evaluate Community Supports authorizations to ensure they are equitable and non-discriminatory. Contractor must have policies and procedures in place for immediate actions that will be undertaken if monitoring/evaluation processes reveal that service authorizations have had an inequitable effect.

C. For Members with an assessed risk of incurring other California Medicaid State Plan services, such as inpatient hospitalizations, skilled nursing facility stays, or emergency department visits, Contractor must develop policies and procedures to ensure appropriate clinical support authorization of Community Supports for Members. Contractor's policies and procedures must include detailed documentation that a Network Provider using their professional judgement has determined it to be medically appropriate for the Member to receive Community Supports as it is likely to reduce or prevent the need for acute care or other California Medicaid State Plan services in accordance with all applicable APLs and to be defined in forthcoming guidance.

D. Contractor must not restrict the authorization of Community Supports only to Members transitioning from WPC or HHP.

E. Contractor must develop and maintain policies and procedures to ensure Members do not experience undue delays pending the authorization process for Community Supports.

1) If Medically Necessary, Contractor must make available the California Medicaid State Plan services that the Community Supports replaces, pending authorization of the requested Community Supports.

2) Contractor must evaluate and document whether a

service is medically appropriate and cost-effective when determining whether to provide Community Supports to a Member. Providing particular Community Supports to a Member in one (1) instance does not automatically mean that providing other Community Supports to the same Member, the same Community Supports to another Member, or the same Community Supports to the same Member in a different instance would be medically appropriate and cost-effective.

F. Contractor must have policies and procedures for expediting the authorization of certain Community Supports for urgent needs, as appropriate, and that identify the circumstances in which any expedited authorization processes apply, in accordance with all applicable APLs.

G. When a Member has requested Community Supports, directly or through a Provider, community-based organization, or other entity, Contractor must notify the requesting entity and Member of Contractor's decision regarding Community Supports authorization, in accordance with all applicable APLs. If the Member is enrolled in ECM, Contractor must ensure the ECM Provider is informed of the Community Supports authorization decision.

H. Member always retains the right to file Appeals and/or Grievances if they request one (1) or more Community Supports offered by Contractor, but were not authorized to receive the requested Community Supports because of a determination that it was not medically appropriate or cost effective.

I. For Members who sought Community Supports offered by Contractor, but were not authorized to receive the Community Supports, Contractor must submit necessary data to monitor Appeals and Grievances as well as follow its standard Grievances and Appeals process outlined in Exhibit A, Attachment 14, Member Grievance and Appeal System and APL 21-011.

25. Referring Members to Community Supports Providers for Community Supports

A. Contractor must develop and maintain policies and procedures to define how Community Supports Provider

referrals will occur. Contractor's policies and procedures must be submitted to DHCS for review and approval prior to implementation.

1) For Members enrolled in ECM, policies and procedures must address how Contractor will work with the ECM Provider to coordinate the Community Supports referral and communicate the outcome of the referral back to the ECM Provider, such as using closed loop referrals.

2) Contractor's policies and procedures must include expectations and procedures to ensure referrals occur in a timely manner after service authorization.

B. If the Member prefers a particular Community Supports Provider are known, Contractor must follow those preferences, to the extent practicable.

C. Contractor must track referrals to Community Supports Providers to verify if the authorized service has been delivered to the Member.

If the Member receiving the Community Support is also receiving ECM, Contractor must monitor to ensure that the ECM Provider tracks whether the Member receives the authorized service from the Community Supports Provider.

D. Contractor must not require Member authorization for Community Supports-related data sharing as a condition of initiating delivery of Community Supports, unless such authorization is required by federal law.

E. Contractor must develop and maintain policies and procedures for its network of Community Supports Providers to:

1) Ensure the Member agrees to receive Community Supports;

2) Where required by law, ensure that Members authorize information sharing with Contractor and all others involved in the Member's care as needed, to support the Member and maximize the benefits of Community Supports, in accordance with all applicable APLs;

3) Provide Contractor with Member-level records of any obtained authorization for Community Supports related data sharing which are required by law, and to facilitate ongoing data sharing with Contractor; and

4) Obtain Member authorization to communicate electronically with the Member, Member's family, legal guardians, authorized representatives, caregivers, and other authorized support persons, if Contractor intends to do so.

26. Data System Requirements and Data Sharing to Support Community Supports

A. Contractor must use systems and processes capable of tracking Community Supports referrals, access to Community Supports, and Grievances and Appeals.

Contractor must support Community Supports Provider access to systems and processes allowing them to track and manage referrals for Community Supports and Member information.

B. Consistent with federal, State, and if applicable, local privacy and confidentiality laws, Contractor must ensure Community Supports Providers have access to the following as part of the referral process to the Community Supports Providers:

1) Demographic and administrative information confirming the referred Member's eligibility and authorization for the requested service;

2) Appropriate administrative, clinical, and social service information that Community Supports Providers might need to effectively provide the requested service; and

3) Billing information necessary to support the Community Supports Providers' ability to submit claims or invoices to Contractor.

C. Contractor must use defined federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with Community Supports Providers and with DHCS.

27. Contractor's Oversight of Community Supports Providers

A. Contractor must comply with all State and federal reporting requirements.

B. Contractor must perform oversight of Community Support Providers, holding them accountable to all Community Supports requirements contained in this Contract, and all applicable APLs.

C. Contractor must use all applicable APLs to develop its Subcontractor Agreements with Community Support Providers and must incorporate all of its Community Supports Provider requirements. Contractor must submit its Subcontractor Agreements with Community Supports Providers to DHCS for review and approval in a form and manner specified by DHCS.

D. To streamline Community Supports implementation, Contractor must ensure the following:

1) Contractor must hold Community Supports Providers responsible for the same reporting requirements as are required of Contractor by DHCS.

2) Contractor must not impose mandatory reporting requirements that are alternative or additional to those required for Encounter and supplemental reporting.

3) Contractor may collaborate with other Medi-Cal Managed Care Health Plans within the same county on reporting requirements and oversight.

E. Contractor must not utilize tools developed or promulgated by NCQA to perform oversight of Community Supports Providers, unless by mutual consent with the Community Supports Provider.

F. Contractor must provide Community Supports training and technical assistance to Community Supports Providers, including in-person sessions, webinars, and calls, as necessary, in addition to Network Provider training requirements as described in Exhibit A, Attachment 7, Provision 5, Network Provider Training.

28. Delegation of Community Supports Administration to

Subcontractors

A. Contractor may enter into Subcontractor Agreements with other entities to administer Community Supports in accordance with the following:

1) Contractor must maintain and be responsible for oversight of compliance with all Contract provisions and Covered Services, as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

2) Contractor is responsible for developing and maintaining DHCS-approved policies and procedures to ensure Subcontractors meet required responsibilities and functions as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

3) Contractor must evaluate the prospective Subcontractor's ability to perform services as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements;

4) Contractor must ensure the Subcontractor's Community Supports Provider capacity is sufficient to serve all Populations of Focus;

5) Contractor must report to DHCS the names of all Subcontractors by type and service(s) provided, and identify the county or counties in which Members are served as described in Exhibit A, Attachment 6, Provision 12, Subcontractor Reports; and

6) Contractor must make all Subcontractor Agreements available to DHCS upon request. Such agreements must contain minimum required information specified by DHCS, including method and amount of compensation as described in Exhibit A, Attachment 6, Provision 14, Network Provider Agreements and Subcontractor Agreements.

B. Contractor must ensure that the Subcontractor Agreement mirror the requirements set forth in this Contract and all applicable APLs, as applicable to the Subcontractor.

C. Contractor may collaborate with its Subcontractors on its approach to Community Supports to minimize divergence in how the Community Supports will be implemented between Contractor and its Subcontractor(s) and ensure a streamlined, seamless experience for Community Supports Providers and Members.

29. Payment of Community Support Providers

A. Contractor must pay contracted Community Supports Providers for the provision of authorized Community Supports to Members in accordance with established Subcontractor Agreements between Contractor and each Community Supports Provider.

B. Contractor must utilize the claims timeline and process as described in Exhibit A, Attachment 8, Provision 5, Claims Processing.

C. Contractor must identify any circumstances under which payment for Community Supports must be expedited to facilitate timely delivery of the Community Supports to the Member, such as recuperative care for an individual who is homeless and being discharged from the hospital.

For such circumstances, Contractor must develop and maintain policies and procedures to ensure payment to the Community Supports Provider is expedited. Contractor must submit these policies and procedures to DHCS for review and approval prior to implementation.

D. Contractor shall ensure Community Supports Providers submit a claim for rendered Community Supports, to the greatest extent possible.

1) If a Community Supports Provider is unable to submit a claim for Community Supports rendered, Contractor must ensure the Community Supports Provider documents services rendered using an invoice approved by DHCS.

2) Upon receipt of such invoice, Contractor must document the Encounter for the Community Supports rendered.

30. DHCS Oversight of Community Supports

A. In the Community Supports MOC, Contractor must include details on the Community Supports Contractor plans to offer, including which counties Community Supports will be offered and its network of Community Supports Providers, in accordance with all applicable APLs.

B. After implementation of Community Supports, Contractor must submit the following data and reports to DHCS to support DHCS oversight of Community Supports:

1) Encounter Data

a) Contractor must submit all Community Supports Encounter Data to DHCS using national standard specifications and code sets to be defined by DHCS. Contractor must be compliant with DHCS guidance on invoicing standards for Contractor to use with Community Supports Providers.

b) Contractor must submit to DHCS all Community Supports Encounter Data, including Encounter Data for Community Supports generated under Subcontractor Agreements.

c) In the event the Community Supports Provider is unable to submit Community Supports Encounter Data to Contractor using the national standard specifications and code sets to be defined by DHCS, Contractor must convert Community Supports Providers' invoice data into the national standard specifications and code sets, for submission to DHCS.

d) Encounter Data, when possible, must include data necessary for DHCS to stratify services by age, sex, race, ethnicity, and language spoken to inform health equity initiatives and efforts to mitigate health disparities undertaken by the DHCS.

2) Supplemental reporting on a schedule and in a form to be defined by DHCS.

C. Contractor must timely submit any related data requested by DHCS, CMS, or an independent entity conducting an evaluation of Community Supports including, but not limited to:

1) Data to evaluate the utilization and effectiveness of a Community Supports.

2) Data necessary to monitor health outcomes and quality metrics at the local and aggregate levels through timely and accurate Encounter Data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex, race, ethnicity, and language spoken.

3) Data necessary to monitor Member Appeals and Grievances associated with Community Supports.

D. In the event of underperformance by Contractor in relation to its administration of Community Supports, DHCS may impose sanctions in accordance with Exhibit E, Attachment 2, Provision 17, Sanctions.

31. Community Supports Quality and Performance Incentive Program

A. Contractor must meet all quality management and Quality Improvement requirements described in Exhibit A, Attachment 4, Quality Improvement System and any additional quality requirements for Community Supports set forth in associated guidance from DHCS.

B. Contractor may participate in a performance incentive program related to adoption of Community Supports, building infrastructure and Provider capacity for Community Supports, related health care quality and outcomes, and other performance milestones and measures, in accordance with DHCS policies and guidance.

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Financial Summary

January 31, 2022

Board of Directors Meeting

March 3, 2022

Nancy Huang, Chief Financial Officer

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Financial Highlights: January 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
879,635	843,578	36,057	4.3%	Member Months	6,034,612	5,895,841	138,771	2.4%
285,333,020	279,694,492	5,638,528	2.0%	Revenues	2,589,167,158	2,267,468,918	321,698,240	14.2%
258,730,344	273,632,808	14,902,464	5.4%	Medical Expenses	2,413,811,587	2,220,319,132	(193,492,455)	(8.7%)
12,934,416	14,886,654	1,952,238	13.1%	Administrative Expenses	85,679,395	102,705,086	17,025,691	16.6%
13,668,260	**(8,824,970)**	**22,493,230**	**254.9%**	**Operating Margin**	**89,676,177**	**(55,555,300)**	**145,231,477**	**261.4%**
(2,574,852)	833,333	(3,408,185)	(409.0%)	Non Operating Income (Loss)	(3,269,905)	5,833,333	(9,103,238)	(156.1%)
11,093,408	**(7,991,637)**	**19,085,045**	**238.8%**	**Change in Net Assets**	**86,406,272**	**(49,721,967)**	**136,128,239**	**273.8%**
90.7%	97.8%	7.2%		Medical Loss Ratio	93.2%	97.9%	4.7%	
4.5%	5.3%	0.8%		Administrative Loss Ratio	3.3%	4.5%	1.2%	
4.8%	(3.2%)	7.9%		Operating Margin Ratio	3.5%	(2.5%)	5.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
90.7%	97.8%	7.2%		*MLR (excluding Directed Payments)	92.9%	97.9%	5.1%	
4.5%	5.3%	0.8%		*ALR (excluding Directed Payments)	3.5%	4.5%	1.0%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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Performance Snapshot: January 2022 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
12.9	(8.2)	21.0	Medi-Cal	81.6	(52.1)	133.7
1.3	(0.6)	1.9	OCC	6.2	(3.6)	9.8
(0.4)	(0.1)	(0.4)	OneCare	(0.7)	(0.8)	0.1
(0.0)	0.1	(0.1)	PACE	2.6	0.9	1.7
0.0	(0.0)	0.0	MSSP	0.0	(0.0)	0.0
13.7	**(8.8)**	**22.5**	**Operating**	**89.7**	**(55.6)**	**145.2**
(2.6)	0.8	(3.4)	Inv./Rental Inc, MCO tax	(3.3)	5.8	(9.1)
(2.6)	**0.8**	**(3.4)**	**Non-Operating**	**(3.3)**	**5.8**	**(9.1)**
11.1	**(8.0)**	**19.1**	**TOTAL**	**86.4**	**(49.7)**	**136.1**

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FY 2021–22: Management Summary

- Change in Net Assets Surplus or (Deficit)
  - MTD (Jan 2022): $11.1 million, favorable to budget $19.1 million or 238.8%, primarily due to higher than anticipated Calendar Year (CY) 2022 Medi-Cal rates and deferred and delayed services
  - YTD (Jul 2021 – Jan 2022): $86.4 million, favorable to budget $136.1 million or 273.8%
- Enrollment
  - MTD: 879,635 members, favorable to budget 36,057 or 4.3%
  - YTD: 6,034,612 members, favorable to budget 138,771 or 2.4%
- Revenue
  - MTD: $285.3 million, favorable to budget $5.6 million or 2.0% driven by Medi-Cal (MC) line of business (LOB):
    - $35.4 million due to CY 2022 rate update, favorable enrollment, prior year retroactive eligibility changes, and Proposition 56 estimates
    - Offset by $27.5 million due to COVID-19 risk corridor
  - YTD: $2.6 billion, favorable to budget $321.7 million or 14.2% driven by MC LOB:
    - $132.6 million of Fiscal Year (FY) 2020 hospital Directed Payments (DP)
    - $155.8 million due to CY 2022 rate update, favorable enrollment, prior year retroactive eligibility changes, and Proposition 56 estimates
    - $48.0 million increase in Long-Term Care (LTC), pharmacy funding from Department of Health Care Services (DHCS), Intergovernmental Transfer (IGT) 10 and Coordinated Care Initiative (CCI)
    - Offset by $29.4 million due to COVID-19 risk corridor

FY 2021–22: Management Summary (cont.)

- Medical Expenses
  - MTD: $258.7 million, favorable to budget $14.9 million or 5.4% driven by MC LOB:
    - Facilities Claims expense favorable variance of $6.7 million due to deferred and delayed services
    - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $6.8 million
    - Reinsurance & Other expense favorable variance of $1.6 million
  - YTD: $2.4 billion, unfavorable to budget $193.5 million or 8.7% driven by MC LOB:
    - Reinsurance & Other expense unfavorable variance of $141.5 million due to FY 2020 hospital DP
    - Provider Capitation expense unfavorable variance of $104.8 million due primarily to the extension of Proposition 56 and short-term supplemental rate increase due to COVID-19
- Administrative Expenses
  - MTD: $12.9 million, favorable to budget $2.0 million or 13.1%
  - YTD: $85.7 million, favorable to budget $17.0 million or 16.6%
- Net Investment Income
  - MTD: ($4.1) million, unfavorable to budget $5.0 million or 594.3%
  - YTD: ($6.7) million, unfavorable to budget $12.6 million or 215.7%
    - Unfavorable variance of $12.6 million is primarily driven by unrealized losses in bond value due to an earlier than expected interest rate increase by the Federal Reserve

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FY 2021–22: Key Financial Ratios

- Medical Loss Ratio (MLR)
  - MTD: Actual 90.7%, Budget 97.8%
  - YTD: Actual 93.2% (92.9% excluding DP), Budget 97.9%
- Administrative Loss Ratio (ALR)
  - MTD: Actual 4.5% , Budget 5.3%
  - YTD: Actual 3.3% (3.5% excluding DP), Budget 4.5%
- Balance Sheet Ratios
  - *Current ratio: 1.65
  - Board-designated reserve funds level: 1.69
  - Net position: $1.4 billion, including required Tangible Net Equity (TNE) of $106.6 million

*Current ratio compares current assets to current liabilities. It measures CalOptima's ability to pay short-term obligations.

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Enrollment Summary: January 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
120,061	117,512	2,549	2.2%	SPD	831,187	820,426	10,761	1.3%
302,328	296,282	6,046	2.0%	TANF Child	2,100,221	2,077,544	22,677	1.1%
116,361	107,018	9,343	8.7%	TANF Adult	784,749	747,809	36,940	4.9%
3,207	3,191	16	0.5%	LTC	22,071	22,337	(266)	(1.2%)
308,405	291,038	17,367	6.0%	MCE	2,091,601	2,028,759	62,842	3.1%
11,841	11,159	682	6.1%	WCM	82,796	78,113	4,683	6.0%
862,203	**826,200**	**36,003**	**4.4%**	**Medi-Cal Total**	**5,912,625**	**5,774,988**	**137,637**	**2.4%**
14,686	**15,179**	**(493)**	**(3.2%)**	**OneCare Connect**	**103,653**	**105,630**	**(1,977)**	**(1.9%)**
2,319	**1,787**	**532**	**29.8%**	**OneCare**	**15,436**	**12,411**	**3,025**	**24.4%**
427	**412**	**15**	**3.6%**	**PACE**	**2,898**	**2,812**	**86**	**3.1%**
452	**455**	**(3)**	**(0.7%)**	**MSSP**	**452**	**455**	**(3)**	**(0.7%)**
879,635	**843,578**	**36,057**	**4.3%**	**CalOptima Total***	**6,034,612**	**5,895,841**	**138,771**	**2.4%**

*Note: CalOptima Total does not include MSSP

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Consolidated Revenue & Expenses: January 2022 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS*	541,957	308,405	11,841	862,203	14,686	2,319	427	452	879,635
REVENUES									
Capitation Revenue	127,719,796	$ 107,404,057	$ 16,554,989	$ 251,678,841	$ 27,374,586	$ 2,565,003	$ 3,495,456	$ 219,134	$ 285,333,020
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	127,719,796	107,404,057	16,554,989	251,678,841	27,374,586	2,565,003	3,495,456	219,134	285,333,020
MEDICAL EXPENSES									
Provider Capitation	38,847,243	44,464,107	9,664,184	92,975,535	10,991,434	793,370			104,760,339
Facilities	25,942,571	26,984,387	7,086,406	60,013,364	4,005,574	979,399	759,147		65,757,485
Professional Claims	20,177,572	11,114,434	1,110,341	32,402,347	1,012,801	120,725	1,194,007		34,729,881
Prescription Drugs	(1,634,506)	823,332	(110,144)	(921,317)	5,879,474	868,759	297,056		6,123,973
MLTSS	31,490,895	3,540,783	1,427,563	36,459,241	1,429,101	7,405	23,141	28,436	37,947,325
Medical Management	3,003,204	1,860,827	398,955	5,262,986	1,088,188	59,261	912,122	123,622	7,446,179
Reinsurance & Other	1,020,972	695,342	19,730	1,736,044	93,415	4,175	131,530		1,965,164
Total Medical Expenses	118,847,952	89,483,211	19,597,037	227,928,200	24,499,988	2,833,095	3,317,003	152,058	258,730,344
Medical Loss Ratio	93.1%	83.3%	118.4%	90.6%	89.5%	110.5%	94.9%	69.4%	90.7%
GROSS MARGIN	**8,871,843**	**17,920,846**	**(3,042,048)**	**23,750,641**	**2,874,598**	**(268,092)**	**178,453**	**67,075**	**26,602,676**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				7,379,811	700,365	78,623	108,727	55,923	8,323,449
Professional fees				504,473	4,575	29,167	1,355	710	540,279
Purchased services				1,003,028	164,603	12,164	47,803		1,227,599
Printing & Postage				364,536	177,340	2,741	25,901		570,519
Depreciation & Amortization				356,506			356		356,862
Other expenses				1,506,153	941	461	2,742	6,154	1,516,450
Indirect cost allocation & Occupancy				(227,402)	552,533	58,503	11,506	4,119	399,258
Total Administrative Expenses				10,887,105	1,600,357	181,659	198,389	66,906	12,934,416
Admin Loss Ratio				4.3%	5.8%	7.1%	5.7%	30.5%	4.5%
INCOME (LOSS) FROM OPERATIONS				12,863,536	1,274,241	(449,751)	(19,936)	170	13,668,260
INVESTMENT INCOME									(4,118,924)
TOTAL MCO TAX				1,543,987					1,543,987
OTHER INCOME				85					85
CHANGE IN NET ASSETS				**$ 14,407,608**	**$1,274,241**	**$ (449,751)**	**$ (19,936)**	**$ 170**	**$ 11,093,408**
BUDGETED CHANGE IN NET ASSETS				(8,184,281)	(609,883)	(70,276)	52,722	(13,252)	(7,991,637)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 22,591,889	$ 1,884,124	$ (379,475)	$ (72,658)	$ 13,422	$ 19,085,045

*Note: Member Months Consolidated Total does not include MSSP

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Consolidated Revenue & Expenses: January 2022 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	Connect	OneCare OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS*	3,738,228	2,091,601	82,796	5,912,625	103,653	15,436	2,898	452	6,034,612
REVENUES									
Capitation Revenue	1,201,948,190	$ 985,216,012	$ 167,759,735	$ 2,354,923,937	$ 190,720,155	$ 19,860,148	$ 23,443,785	$ 219,134	$ 2,589,167,158
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,201,948,190	985,216,012	167,759,735	2,354,923,937	190,720,155	19,860,148	23,443,785	219,134	2,589,167,158
MEDICAL EXPENSES									
Provider Capitation	330,973,215	352,669,187	65,898,018	749,540,419	76,841,378	5,426,088			831,807,886
Facilities	177,705,782	176,612,678	37,813,120	392,131,580	27,914,155	6,125,528	4,848,950		431,020,212
Professional Claims	149,383,378	75,665,912	9,915,087	234,964,376	7,739,535	727,275	5,636,450		249,067,637
Prescription Drugs	129,028,128	176,567,011	40,405,886	346,001,025	42,942,475	6,358,111	2,224,807		397,526,418
MLTSS	256,920,462	28,253,807	13,181,407	298,355,675	10,026,501	384,145	356,257	28,436	309,151,014
Medical Management	17,778,158	10,584,353	2,274,999	30,637,511	7,192,711	259,929	5,767,919	123,622	43,981,691
Reinsurance & Other	93,145,911	55,797,682	82,119	149,025,712	1,331,857	24,719	874,441		151,256,728
Total Medical Expenses	1,154,935,034	876,150,628	169,570,636	2,200,656,299	173,988,611	19,305,795	19,708,824	152,058	2,413,811,587
Medical Loss Ratio	96.1%	88.9%	101.1%	93.4%	91.2%	97.2%	84.1%	69.4%	93.2%
GROSS MARGIN	**47,013,156**	**109,065,384**	**(1,810,901)**	**154,267,638**	**16,731,543**	**554,353**	**3,734,961**	**67,075**	**175,355,571**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				49,686,037	5,100,802	535,030	791,121	55,923	56,168,914
Professional fees				1,808,114	174,156	210,932	7,251	710	2,201,163
Purchased services				6,937,455	756,141	77,807	98,158		7,869,561
Printing & Postage				2,274,397	649,391	67,504	95,615		3,086,907
Depreciation & Amortization				2,665,223			6,403		2,671,626
Other expenses				10,926,559	7,191	1,076	42,569	6,154	10,983,549
Indirect cost allocation & Occupancy				(1,649,320)	3,867,729	409,518	65,630	4,119	2,697,675
Total Administrative Expenses				72,648,464	10,555,410	1,301,866	1,106,748	66,906	85,679,395
Admin Loss Ratio				3.1%	5.5%	6.6%	4.7%	30.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				81,619,174	6,176,133	(747,513)	2,628,213	170	89,676,177
INVESTMENT INCOME									(6,749,875)
TOTAL MCO TAX				3,471,169					3,471,169
OTHER INCOME				8,801					8,801
CHANGE IN NET ASSETS				**$ 85,099,144**	**$ 6,176,133**	**$ (747,513)**	**$ 2,628,213**	**$ 170**	**$ 86,406,272**
BUDGETED CHANGE IN NET ASSETS				(52,060,005)	(3,606,305)	(799,666)	923,928	(13,252)	(49,721,967)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 137,159,149	$ 9,782,438	$ 52,153	$ 1,704,285	$ 13,422	$ 136,128,239

*Note: Member Months Consolidated Total does not include MSSP

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Balance Sheet: As of January 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$763,869,915	Accounts Payable	$22,131,513
Short-term Investments	954,632,769	Medical Claims liability	962,778,097
Capitation receivable	162,280,879	Accrued Payroll Liabilities	12,287,670
Receivables - Other	41,917,744	Deferred Revenue	9,750,821
Prepaid expenses	15,154,070	Deferred Lease Obligations	109,958
		Capitation and Withholds	168,727,670
Total Current Assets	**1,937,855,376**	**Total Current Liabilities**	**1,175,785,728**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	7,714,655		
505 City Parkway West	52,168,012		
	106,133,752		
Less: accumulated depreciation	(61,573,526)		
Capital assets, net	44,560,226		
		Other (than pensions) post employment benefits liability	31,956,845
Other Assets		Net Pension Liabilities	30,384,981
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,238,127,554**
Cash and Cash Equivalents	4,050,633		
Investments	579,120,317	**Deferred Inflows**	
Total Board-designated Assets	583,170,950	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
		Change in Assumptions	2,709,945
Total Other Assets	640,269,863	OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,622,685,465**	TNE	106,628,967
		Funds in Excess of TNE	1,288,558,098
Deferred Outflows		**TOTAL NET POSITION**	1,395,187,065
Contributions	1,508,025		
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,637,677,762**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,637,677,762**

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Board Designated Reserve and TNE Analysis: As of January 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	239,062,207				
	Tier 1 - MetLife	237,950,240				
Board-designated Reserve		477,012,447	377,095,460	584,405,929	99,916,987	(107,393,482)
	Tier 2 - Payden & Rygel	53,105,626				
	Tier 2 - MetLife	53,052,876				
TNE Requirement		106,158,503	106,628,967	106,628,967	(470,465)	(470,465)
	Consolidated:	**583,170,949**	**483,724,428**	**691,034,896**	**99,446,522**	**(107,863,947)**
	Current reserve level	*1.69*	*1.40*	*2.00*		

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Our Mission

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

CalOptima
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UNAUDITED FINANCIAL STATEMENTS

January 2022

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CalOptima - Consolidated
Financial Highlights
For the Seven Months Ended January 31, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
879,635	843,578	36,057	4.3%	Member Months	6,034,612	5,895,841	138,771	2.4%
285,333,020	279,694,492	5,638,528	2.0%	Revenues	2,589,167,158	2,267,468,918	321,698,240	14.2%
258,730,344	273,632,808	14,902,464	5.4%	Medical Expenses	2,413,811,587	2,220,319,132	(193,492,455)	(8.7%)
12,934,416	14,886,654	1,952,238	13.1%	Administrative Expenses	85,679,395	102,705,086	17,025,691	16.6%
13,668,260	**(8,824,970)**	**22,493,230**	**254.9%**	**Operating Margin**	**89,676,177**	**(55,555,300)**	**145,231,477**	**261.4%**
(2,574,852)	833,333	(3,408,185)	(409.0%)	Non Operating Income (Loss)	(3,269,905)	5,833,333	(9,103,238)	(156.1%)
11,093,408	**(7,991,637)**	**19,085,045**	**238.8%**	**Change in Net Assets**	**86,406,272**	**(49,721,967)**	**136,128,239**	**273.8%**
90.7%	97.8%	7.2%		Medical Loss Ratio	93.2%	97.9%	4.7%	
4.5%	5.3%	0.8%		Administrative Loss Ratio	3.3%	4.5%	1.2%	
4.8%	(3.2%)	7.9%		Operating Margin Ratio	3.5%	(2.5%)	5.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		
90.7%	97.8%	7.2%		*MLR (excluding Directed Payments)	92.9%	97.9%	5.1%	
4.5%	5.3%	0.8%		*ALR (excluding Directed Payments)	3.5%	4.5%	1.0%	

*CalOptima updated the category of Directed Payments per Department of Health Care Services instructions

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CalOptima
Financial Dashboard
For the Seven Months Ended January 31, 2022

MONTH - TO - DATE

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	862,203	826,200	36,003	4.4%
OneCare Connect	14,686	15,179	(493)	(3.2%)
OneCare	2,319	1,787	532	29.8%
PACE	427	412	15	3.6%
MSSP	452	455	(3)	(0.7%)
Total*	879,635	843,578	36,057	4.3%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 14,408	$ (8,184)	$ 22,592	276.1%
OneCare Connect	1,274	(610)	1,884	308.9%
OneCare	(450)	(70)	(380)	(542.9%)
PACE	(20)	53	(73)	(137.7%)
MSSP	-	(13)	13	100.0%
505 Bldg.	-	-	-	0.0%
Investment Income	(4,119)	833	(4,952)	(594.5%)
Total	$ 11,093	$ (7,991)	$ 19,084	238.8%

MLR	Actual	Budget	% Point Var
Medi-Cal	90.6%	98.2%	7.7
OneCare Connect	89.5%	95.5%	6.0
OneCare	110.5%	95.1%	(15.4)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 10,887	$ 12,468	$ 1,581	12.7%
OneCare Connect	1,600	1,930	330	17.1%
OneCare	182	179	(3)	(1.6%)
PACE	198	238	40	16.6%
MSSP	67	71	5	6.4%
Total	$ 12,934	$ 14,887	$ 1,952	13.1%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,082	1,205	123
OneCare Connect	181	210	29
OneCare	10	9	(1)
PACE	90	117	27
MSSP	17	18	1
Total	1,380	1,558	179

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	797	686	111
OneCare Connect	81	72	9
OneCare	232	192	40
PACE	5	4	1
MSSP	26	25	1
Total	1,141	979	162

*Note: Total Enrollment does not include MSSP

YEAR - TO - DATE

Year To Date Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	5,912,625	5,774,988	137,637	2.4%
OneCare Connect	103,653	105,630	(1,977)	(1.9%)
OneCare	15,436	12,411	3,025	24.4%
PACE	2,898	2,812	86	3.1%
MSSP	452	455	(3)	(0.7%)
Total*	6,034,612	5,895,841	138,771	2.4%

Change in Net Assets (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 85,099	$ (52,060)	$ 137,159	263.5%
OneCare Connect	6,176	(3,606)	9,782	271.3%
OneCare	(748)	(800)	52	6.5%
PACE	2,628	924	1,704	184.4%
MSSP	-	(13)	13	100.0%
505 Bldg.	-	-	-	0.0%
Investment Income	(6,750)	5,833	(12,583)	(215.7%)
Total	$ 86,405	$ (49,722)	$ 136,127	273.8%

MLR	Actual	Budget	% Point Var
Medi-Cal	93.4%	98.3%	4.9
OneCare Connect	91.2%	95.1%	3.9
OneCare	97.2%	96.8%	(0.4)

Administrative Cost (000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 72,648	$ 86,669	$ 14,021	16.2%
OneCare Connect	10,555	13,129	2,574	19.6%
OneCare	1,302	1,256	(46)	(3.7%)
PACE	1,107	1,579	472	29.9%
MSSP	67	71	5	6.4%
Total	$ 85,679	$ 102,705	$ 17,026	16.6%

Total FTE's YTD	Actual	Budget	Fav / (Unfav)
Medi-Cal	7,566	8,511	944
OneCare Connect	1,317	1466	149
OneCare	69	65	(4)
PACE	641	795	154
MSSP	17	18	1
Total	9,611	10,854	1,244

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal	781	679	103
OneCare Connect	79	72	7
OneCare	222	191	32
PACE	5	4	1
MSSP	26	25	1
Total	1,113	970	143

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the One Month Ended January 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	879,635		843,578		36,057	
REVENUE						
Medi-Cal	$ 251,678,841	$ 291.90	$ 244,696,198	$ 296.17	$ 6,982,643	$ (4.27)
OneCare Connect	27,374,586	1,863.99	29,248,042	1,926.88	(1,873,456)	(62.89)
OneCare	2,565,003	1,106.08	2,195,820	1,228.77	369,183	(122.69)
PACE	3,495,456	8,186.08	3,351,342	8,134.33	144,114	51.75
MSSP	219,134	484.81	203,090	446.35	16,044	38.46
Total Operating Revenue	285,333,020	324.38	279,694,492	331.56	5,638,528	(7.18)
MEDICAL EXPENSES						
Medi-Cal	227,928,200	264.36	240,412,398	290.99	12,484,198	26.63
OneCare Connect	24,499,988	1,668.25	27,927,618	1,839.89	3,427,630	171.64
OneCare	2,833,095	1,221.69	2,087,269	1,168.03	(745,826)	(53.66)
PACE	3,317,003	7,768.16	3,060,650	7,428.76	(256,353)	(339.40)
MSSP	152,058	336.41	144,873	318.40	(7,185)	(18.01)
Total Medical Expenses	258,730,344	294.13	273,632,808	324.37	14,902,464	30.24
GROSS MARGIN	26,602,676	30.25	6,061,684	7.19	20,540,992	23.06
ADMINISTRATIVE EXPENSES						
Salaries and benefits	8,323,449	9.46	9,319,755	11.05	996,306	1.59
Professional fees	540,279	0.61	860,396	1.02	320,117	0.41
Purchased services	1,227,599	1.40	1,147,039	1.36	(80,560)	(0.04)
Printing & Postage	570,519	0.65	556,998	0.66	(13,521)	0.01
Depreciation & Amortization	356,862	0.41	492,900	0.58	136,038	0.17
Other expenses	1,516,450	1.72	2,070,632	2.45	554,182	0.73
Indirect cost allocation & Occupancy expense	399,258	0.45	438,934	0.52	39,676	0.07
Total Administrative Expenses	12,934,416	14.70	14,886,654	17.65	1,952,238	2.95
INCOME (LOSS) FROM OPERATIONS	13,668,260	15.54	(8,824,970)	(10.46)	22,493,230	26.00
INVESTMENT INCOME						
Interest income	585,639	0.67	833,333	0.99	(247,694)	(0.32)
Realized gain/(loss) on investments	(454,870)	(0.52)	-	-	(454,870)	(0.52)
Unrealized gain/(loss) on investments	(4,249,693)	(4.83)	-	-	(4,249,693)	(4.83)
Total Investment Income	(4,118,924)	(4.68)	833,333	0.99	(4,952,257)	(5.67)
TOTAL MCO TAX	1,543,987	1.76	-	-	1,543,987	1.76
OTHER INCOME	85	-	-	-	85	-
CHANGE IN NET ASSETS	**11,093,408**	**12.61**	**(7,991,637)**	**(9.47)**	**19,085,045**	**22.08**
MEDICAL LOSS RATIO	**90.7%**		**97.8%**		**7.2%**	
ADMINISTRATIVE LOSS RATIO	**4.5%**		**5.3%**		**0.8%**	

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CalOptima - Consolidated
Statement of Revenues and Expenses
For the Seven Months Ended January 31, 2022

	Actual		Budget		Variance	
	$	PMPM	$	PMPM	$	PMPM
MEMBER MONTHS	6,034,612		5,895,841		138,771	
REVENUE						
Medi-Cal	$ 2,354,923,937	$ 398.29	$ 2,035,413,975	$ 352.45	$ 319,509,962	$ 45.84
OneCare Connect	190,720,155	1,839.99	194,637,809	1,842.64	(3,917,654)	(2.65)
OneCare	19,860,148	1,286.61	14,400,380	1,160.29	5,459,768	126.32
PACE	23,443,785	8,089.64	22,813,664	8,112.97	630,121	(23.33)
MSSP	219,134	484.81	203,090	446.35	16,044	38.46
Total Operating Revenue	2,589,167,158	429.05	2,267,468,918	384.59	321,698,240	44.46
MEDICAL EXPENSES						
Medi-Cal	2,200,656,299	372.20	2,000,804,611	346.46	(199,851,688)	(25.74)
OneCare Connect	173,988,611	1,678.57	185,115,074	1,752.49	11,126,463	73.92
OneCare	19,305,795	1,250.70	13,944,076	1,123.53	(5,361,719)	(127.17)
PACE	19,708,824	6,800.84	20,310,498	7,222.79	601,674	421.95
MSSP	152,058	336.41	144,873	318.40	(7,185)	(18.01)
Total Medical Expenses	2,413,811,587	399.99	2,220,319,132	376.59	(193,492,455)	(23.40)
GROSS MARGIN	175,355,571	29.06	47,149,786	8.00	128,205,785	21.06
ADMINISTRATIVE EXPENSES						
Salaries and benefits	56,168,914	9.31	65,285,521	11.07	9,116,607	1.76
Professional fees	2,201,163	0.36	4,839,284	0.82	2,638,121	0.46
Purchased services	7,869,561	1.30	9,067,808	1.54	1,198,247	0.24
Printing & Postage	3,086,907	0.51	3,898,986	0.66	812,079	0.15
Depreciation & Amortization	2,671,626	0.44	3,450,300	0.59	778,674	0.15
Other expenses	10,983,549	1.82	13,090,649	2.22	2,107,100	0.40
Indirect cost allocation & Occupancy expense	2,697,675	0.45	3,072,538	0.52	374,863	0.07
Total Administrative Expenses	85,679,395	14.20	102,705,086	17.42	17,025,691	3.22
INCOME (LOSS) FROM OPERATIONS	89,676,177	14.86	(55,555,300)	(9.42)	145,231,477	24.28
INVESTMENT INCOME						
Interest income	4,271,489	0.71	5,833,333	0.99	(1,561,844)	(0.28)
Realized gain/(loss) on investments	(250,948)	(0.04)	-	-	(250,948)	(0.04)
Unrealized gain/(loss) on investments	(10,770,416)	(1.78)	-	-	(10,770,416)	(1.78)
Total Investment Income	(6,749,875)	(1.12)	5,833,333	0.99	(12,583,208)	(2.11)
TOTAL MCO TAX	3,471,169	0.58	-	-	3,471,169	0.58
OTHER INCOME	8,801	-	-	-	8,801	-
CHANGE IN NET ASSETS	**86,406,272**	**14.32**	**(49,721,967)**	**(8.43)**	**136,128,239**	**22.75**
MEDICAL LOSS RATIO	**93.2%**		**97.9%**		**4.7%**	
ADMINISTRATIVE LOSS RATIO	**3.3%**		**4.5%**		**1.2%**	

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended January 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	OneCare Connect	OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS*	541,957	308,405	11,841	862,203	14,686	2,319	427	452	879,635
REVENUES									
Capitation Revenue	127,719,796	$ 107,404,057	$ 16,554,989	$ 251,678,841	$ 27,374,586	$ 2,565,003	$ 3,495,456	$ 219,134	$ 285,333,020
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	127,719,796	107,404,057	16,554,989	251,678,841	27,374,586	2,565,003	3,495,456	219,134	285,333,020
MEDICAL EXPENSES									
Provider Capitation	38,847,243	44,464,107	9,664,184	92,975,535	10,991,434	793,370			104,760,339
Facilities	25,942,571	26,984,387	7,086,406	60,013,364	4,005,574	979,399	759,147		65,757,485
Professional Claims	20,177,572	11,114,434	1,110,341	32,402,347	1,012,801	120,725	1,194,007		34,729,881
Prescription Drugs	(1,634,506)	823,332	(110,144)	(921,317)	5,879,474	868,759	297,056		6,123,973
MLTSS	31,490,895	3,540,783	1,427,563	36,459,241	1,429,101	7,405	23,141	28,436	37,947,325
Medical Management	3,003,204	1,860,827	398,955	5,262,986	1,088,188	59,261	912,122	123,622	7,446,179
Reinsurance & Other	1,020,972	695,342	19,730	1,736,044	93,415	4,175	131,530		1,965,164
Total Medical Expenses	118,847,952	89,483,211	19,597,037	227,928,200	24,499,988	2,833,095	3,317,003	152,058	258,730,344
Medical Loss Ratio	93.1%	83.3%	118.4%	90.6%	89.5%	110.5%	94.9%	69.4%	90.7%
GROSS MARGIN	**8,871,843**	**17,920,846**	**(3,042,048)**	**23,750,641**	**2,874,598**	**(268,092)**	**178,453**	**67,075**	**26,602,676**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				7,379,811	700,365	78,623	108,727	55,923	8,323,449
Professional fees				504,473	4,575	29,167	1,355	710	540,279
Purchased services				1,003,028	164,603	12,164	47,803		1,227,599
Printing & Postage				364,536	177,340	2,741	25,901		570,519
Depreciation & Amortization				356,506			356		356,862
Other expenses				1,506,153	941	461	2,742	6,154	1,516,450
Indirect cost allocation & Occupancy				(227,402)	552,533	58,503	11,506	4,119	399,258
Total Administrative Expenses				10,887,105	1,600,357	181,659	198,389	66,906	12,934,416
Admin Loss Ratio				4.3%	5.8%	7.1%	5.7%	30.5%	4.5%
INCOME (LOSS) FROM OPERATIONS				12,863,536	1,274,241	(449,751)	(19,936)	170	13,668,260
INVESTMENT INCOME									(4,118,924)
TOTAL MCO TAX				1,543,987					1,543,987
OTHER INCOME				85					85
CHANGE IN NET ASSETS				**$ 14,407,608**	**$ 1,274,241**	**$ (449,751)**	**$ (19,936)**	**$ 170**	**$ 11,093,408**
BUDGETED CHANGE IN NET ASSETS				(8,184,281)	(609,883)	(70,276)	52,722	(13,252)	(7,991,637)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 22,591,889	$ 1,884,124	$ (379,475)	$ (72,658)	$ 13,422	$ 19,085,045

*Note: Member Months Consolidated Total does not include MSSP

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Seven Months Ended January 31, 2022

	Medi-Cal Classic	Medi-Cal Expansion	Whole Child Model	Total Medi-Cal	Connect	OneCare OneCare	PACE	MSSP	Consolidated
MEMBER MONTHS*	3,738,228	2,091,601	82,796	5,912,625	103,653	15,436	2,898	452	6,034,612
REVENUES									
Capitation Revenue	1,201,948,190	$ 985,216,012	$ 167,759,735	$ 2,354,923,937	$ 190,720,155	$ 19,860,148	$ 23,443,785	$ 219,134	$ 2,589,167,158
Other Income	-	-	-	-	-	-	-	-	-
Total Operating Revenue	1,201,948,190	985,216,012	167,759,735	2,354,923,937	190,720,155	19,860,148	23,443,785	219,134	2,589,167,158
MEDICAL EXPENSES									
Provider Capitation	330,973,215	352,669,187	65,898,018	749,540,419	76,841,378	5,426,088			831,807,886
Facilities	177,705,782	176,612,678	37,813,120	392,131,580	27,914,155	6,125,528	4,848,950		431,020,212
Professional Claims	149,383,378	75,665,912	9,915,087	234,964,376	7,739,535	727,275	5,636,450		249,067,637
Prescription Drugs	129,028,128	176,567,011	40,405,886	346,001,025	42,942,475	6,358,111	2,224,807		397,526,418
MLTSS	256,920,462	28,253,807	13,181,407	298,355,675	10,026,501	384,145	356,257	28,436	309,151,014
Medical Management	17,778,158	10,584,353	2,274,999	30,637,511	7,192,711	259,929	5,767,919	123,622	43,981,691
Reinsurance & Other	93,145,911	55,797,682	82,119	149,025,712	1,331,857	24,719	874,441		151,256,728
Total Medical Expenses	1,154,935,034	876,150,628	169,570,636	2,200,656,299	173,988,611	19,305,795	19,708,824	152,058	2,413,811,587
Medical Loss Ratio	96.1%	88.9%	101.1%	93.4%	91.2%	97.2%	84.1%	69.4%	93.2%
GROSS MARGIN	**47,013,156**	**109,065,384**	**(1,810,901)**	**154,267,638**	**16,731,543**	**554,353**	**3,734,961**	**67,075**	**175,355,571**
ADMINISTRATIVE EXPENSES									
Salaries & Benefits				49,686,037	5,100,802	535,030	791,121	55,923	56,168,914
Professional fees				1,808,114	174,156	210,932	7,251	710	2,201,163
Purchased services				6,937,455	756,141	77,807	98,158		7,869,561
Printing & Postage				2,274,397	649,391	67,504	95,615		3,086,907
Depreciation & Amortization				2,665,223			6,403		2,671,626
Other expenses				10,926,559	7,191	1,076	42,569	6,154	10,983,549
Indirect cost allocation & Occupancy				(1,649,320)	3,867,729	409,518	65,630	4,119	2,697,675
Total Administrative Expenses				72,648,464	10,555,410	1,301,866	1,106,748	66,906	85,679,395
Admin Loss Ratio				3.1%	5.5%	6.6%	4.7%	30.5%	3.3%
INCOME (LOSS) FROM OPERATIONS				81,619,174	6,176,133	(747,513)	2,628,213	170	89,676,177
INVESTMENT INCOME									(6,749,875)
TOTAL MCO TAX				3,471,169					3,471,169
OTHER INCOME				8,801					8,801
CHANGE IN NET ASSETS				**$ 85,099,144**	**$ 6,176,133**	**$ (747,513)**	**$ 2,628,213**	**$ 170**	**$ 86,406,272**
BUDGETED CHANGE IN NET ASSETS				(52,060,005)	(3,606,305)	(799,666)	923,928	(13,252)	(49,721,967)
VARIANCE TO BUDGET - FAV (UNFAV)				$ 137,159,149	$ 9,782,438	$ 52,153	$ 1,704,285	$ 13,422	$ 136,128,239

*Note: Member Months Consolidated Total does not include MSSP

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January 31, 2022 Unaudited Financial Statements

SUMMARY MONTHLY RESULTS:

- Change in Net Assets is $11.1 million, $19.1 million favorable to budget
- Operating surplus is $13.7 million, with a deficit in non-operating income of $2.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $86.4 million, $136.1 million favorable to budget
- Operating surplus is $89.7 million, with a deficit in non-operating income of $3.3 million

Change in Net Assets by Line of Business (LOB) ($ millions):

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
12.9	(8.2)	21.0	Medi-Cal	81.6	(52.1)	133.7
1.3	(0.6)	1.9	OCC	6.2	(3.6)	9.8
(0.4)	(0.1)	(0.4)	OneCare	(0.7)	(0.8)	0.1
(0.0)	0.1	(0.1)	PACE	2.6	0.9	1.7
0.0	(0.0)	0.0	MSSP	0.0	(0.0)	0.0
13.7	**(8.8)**	**22.5**	**Operating**	**89.7**	**(55.6)**	**145.2**
(2.6)	0.8	(3.4)	Inv./Rental Inc, MCO tax	(3.3)	5.8	(9.1)
(2.6)	**0.8**	**(3.4)**	**Non-Operating**	**(3.3)**	**5.8**	**(9.1)**
11.1	**(8.0)**	**19.1**	**TOTAL**	**86.4**	**(49.7)**	**136.1**

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CalOptima - Consolidated
Enrollment Summary
For the Seven Months Ended January 31, 2022

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance	Enrollment (by Aid Category)	Actual	Budget	$ Variance	% Variance
120,061	117,512	2,549	2.2%	SPD	831,187	820,426	10,761	1.3%
302,328	296,282	6,046	2.0%	TANF Child	2,100,221	2,077,544	22,677	1.1%
116,361	107,018	9,343	8.7%	TANF Adult	784,749	747,809	36,940	4.9%
3,207	3,191	16	0.5%	LTC	22,071	22,337	(266)	(1.2%)
308,405	291,038	17,367	6.0%	MCE	2,091,601	2,028,759	62,842	3.1%
11,841	11,159	682	6.1%	WCM	82,796	78,113	4,683	6.0%
862,203	**826,200**	**36,003**	**4.4%**	**Medi-Cal Total**	**5,912,625**	**5,774,988**	**137,637**	**2.4%**
14,686	**15,179**	**(493)**	**(3.2%)**	**OneCare Connect**	**103,653**	**105,630**	**(1,977)**	**(1.9%)**
2,319	**1,787**	**532**	**29.8%**	**OneCare**	**15,436**	**12,411**	**3,025**	**24.4%**
427	**412**	**15**	**3.6%**	**PACE**	**2,898**	**2,812**	**86**	**3.1%**
452	**455**	**(3)**	**(0.7%)**	**MSSP**	**452**	**455**	**(3)**	**(0.7%)**
879,635	**843,578**	**36,057**	**4.3%**	**CalOptima Total***	**6,034,612**	**5,895,841**	**138,771**	**2.4%**
				Enrollment (by Network)				
200,454	192,083	8,371	4.4%	HMO	1,375,428	1,337,841	37,587	2.8%
231,452	227,321	4,131	1.8%	PHC	1,604,722	1,593,802	10,920	0.7%
210,269	202,524	7,745	3.8%	Shared Risk Group	1,445,999	1,419,928	26,071	1.8%
220,028	204,272	15,756	7.7%	Fee for Service	1,486,476	1,423,417	63,059	4.4%
862,203	**826,200**	**36,003**	**4.4%**	**Medi-Cal Total**	**5,912,625**	**5,774,988**	**137,637**	**2.4%**
14,686	**15,179**	**(493)**	**(3.2%)**	**OneCare Connect**	**103,653**	**105,630**	**(1,977)**	**(1.9%)**
2,319	**1,787**	**532**	**29.8%**	**OneCare**	**15,436**	**12,411**	**3,025**	**24.4%**
427	**412**	**15**	**3.6%**	**PACE**	**2,898**	**2,812**	**86**	**3.1%**
452	**455**	**(3)**	**(0.7%)**	**MSSP**	**452**	**455**	**(3)**	**(0.7%)**
879,635	**843,578**	**36,057**	**4.3%**	**CalOptima Total***	**6,034,612**	**5,895,841**	**138,771**	**2.4%**

*Note: CalOptima Total does not include MSSP

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CalOptima
Enrollment Trend by Network
Fiscal Year 2022

	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	YTD Actual	YTD Budget	Variance
HMOs															
SPD	10,759	10,772	10,796	10,750	10,821	10,837	10,841						75,576	75,597	(21)
TANF Child	57,684	57,453	57,592	57,944	58,108	58,236	58,526						405,543	399,122	6,421
TANF Adult	33,827	34,099	34,339	34,622	35,046	35,411	35,758						243,102	232,084	11,018
LTC		1	3	1		1	1						7		7
MCE	88,797	89,334	90,159	91,017	91,516	92,159	93,225						636,207	616,968	19,239
WCM	2,114	2,193	2,177	2,133	2,130	2,143	2,103						14,993	14,070	923
Total	**193,181**	**193,852**	**195,066**	**196,467**	**197,621**	**198,787**	**200,454**						**1,375,428**	**1,337,841**	**37,587**
PHCs															
SPD	6,896	6,819	6,942	6,915	6,953	6,926	6,861						48,312	49,817	(1,505)
TANF Child	155,214	154,985	155,440	155,771	156,156	156,251	156,692						1,090,509	1,082,719	7,790
TANF Adult	14,006	14,054	14,197	14,390	14,667	14,851	14,985						101,150	96,617	4,533
LTC		2	1			1							4		4
MCE	44,256	44,359	44,580	44,754	44,973	45,241	45,668						313,831	316,545	(2,714)
WCM	7,304	7,368	7,236	7,322	7,178	7,262	7,246						50,916	48,104	2,812
Total	**227,676**	**227,587**	**228,396**	**229,152**	**229,927**	**230,532**	**231,452**						**1,604,722**	**1,593,802**	**10,920**
Shared Risk Groups															
SPD	10,063	10,104	10,074	10,003	10,122	10,095	10,096						70,557	72,290	(1,733)
TANF Child	59,085	58,837	58,641	58,541	58,523	58,347	58,363						410,337	416,875	(6,538)
TANF Adult	33,013	33,123	33,374	33,745	34,109	34,482	34,824						236,670	231,926	4,744
LTC	1	1	1		1								4		4
MCE	99,994	100,643	101,666	102,780	103,620	104,418	105,563						718,684	688,925	29,759
WCM	1,373	1,368	1,394	1,400	1,395	1,394	1,423						9,747	9,912	(165)
Total	**203,529**	**204,076**	**205,150**	**206,469**	**207,770**	**208,736**	**210,269**						**1,445,999**	**1,419,928**	**26,071**
Fee for Service (Dual)															
SPD	79,829	80,117	80,139	80,438	80,738	80,494	81,326						563,081	550,125	12,956
TANF Child	1	1	1	1	1	1	1						7		7
TANF Adult	1,318	1,351	1,392	1,408	1,435	1,465	1,529						9,898	8,132	1,766
LTC	2,788	2,778	2,806	2,847	2,864	2,870	2,914						19,867	20,209	(342)
MCE	3,612	3,813	4,013	4,268	4,489	4,889	4,982						30,066	18,189	11,877
WCM	16	16	18	20	15	18	16						119	105	14
Total	**87,564**	**88,076**	**88,369**	**88,982**	**89,542**	**89,737**	**90,768**						**623,038**	**596,760**	**26,278**
Fee for Service (Non-Dual - Total)															
SPD	10,163	10,047	10,616	10,358	10,832	10,708	10,937						73,661	72,597	1,064
TANF Child	26,720	26,952	27,715	28,188	27,730	27,774	28,746						193,825	178,828	14,997
TANF Adult	26,224	26,653	27,382	27,916	28,150	28,339	29,265						193,929	179,050	14,879
LTC	309	314	305	316	321	332	292						2,189	2,128	61
MCE	53,947	54,384	55,449	56,467	56,714	56,885	58,967						392,813	388,132	4,681
WCM	993	962	999	1,030	1,009	975	1,053						7,021	5,922	1,099
Total	**118,356**	**119,312**	**122,466**	**124,275**	**124,756**	**125,013**	**129,260**						**863,438**	**826,657**	**36,781**
SPD	117,710	117,859	118,567	118,464	119,466	119,060	120,061						831,187	820,426	10,761
TANF Child	298,704	298,228	299,389	300,445	300,518	300,609	302,328						2,100,221	2,077,544	22,677
TANF Adult	108,388	109,280	110,684	112,081	113,407	114,548	116,361						784,749	747,809	36,940
LTC	3,098	3,096	3,116	3,164	3,186	3,204	3,207						22,071	22,337	(266)
MCE	290,606	292,533	295,867	299,286	301,312	303,592	308,405						2,091,601	2,028,759	62,842
WCM	11,800	11,907	11,824	11,905	11,727	11,792	11,841						82,796	78,113	4,683
Total Medi-Cal MM	**830,306**	**832,903**	**839,447**	**845,345**	**849,616**	**852,805**	**862,203**						**5,912,625**	**5,774,988**	**137,637**
OneCare Connect	**14,688**	**14,819**	**14,817**	**14,833**	**14,877**	**14,933**	**14,686**						**103,653**	**105,630**	**(1,977)**
OneCare	**2,019**	**2,110**	**2,152**	**2,232**	**2,274**	**2,330**	**2,319**						**15,436**	**12,411**	**3,025**
PACE	**401**	**407**	**409**	**418**	**415**	**421**	**427**						**2,898**	**2,812**	**86**
MSSP							**452**						**452**	**455**	**(3)**
Grand Total*	**847,414**	**850,239**	**856,825**	**862,828**	**867,182**	**870,489**	**879,635**						**6,034,612**	**5,895,841**	**138,771**

*Note: Grand Total does not include MSSP

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ENROLLMENT:

Overall, January enrollment was 879,635

- Favorable to budget 36,057 or 4.3%
- Increased 9,146 or 1.1% from Prior Month (PM) (December 2021)
- Increased 61,252 or 7.5% from Prior Year (PY) (January 2021)

Medi-Cal enrollment was 862,203

- Favorable to budget 36,003 or 4.4%
  - Medi-Cal Expansion (MCE) favorable 17,367
  - Temporary Assistance for Needy Families (TANF) favorable 15,389
  - Seniors and Persons with Disabilities (SPD) favorable 2,549
  - Whole Child Model (WCM) favorable 682
  - Long-Term Care (LTC) favorable 16
- Increased 9,398 from PM

OneCare Connect enrollment was 14,686

- Unfavorable to budget 493 or 3.2%
- Decreased 247 from PM

OneCare enrollment was 2,319

- Favorable to budget 532 or 29.8%
- Decreased 11 from PM

PACE enrollment was 427

- Favorable to budget 15 or 3.6%
- Increased 6 from PM

CalOptima
Medi-Cal
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
862,203	**826,200**	**36,003**	**4.4%**	**Member Months**	**5,912,625**	**5,774,988**	**137,637**	**2.4%**
				Revenues				
251,678,841	244,696,198	6,982,643	2.9%	Capitation Revenue	2,354,923,937	2,035,413,975	319,509,962	15.7%
251,678,841	**244,696,198**	**6,982,643**	**2.9%**	**Total Operating Revenue**	**2,354,923,937**	**2,035,413,975**	**319,509,962**	**15.7%**
				Medical Expenses				
92,975,535	89,753,347	(3,222,188)	(3.6%)	Provider Capitation	749,540,419	644,758,941	(104,781,478)	(16.3%)
60,013,364	66,686,155	6,672,791	10.0%	Facilities Claims	392,131,580	449,077,317	56,945,737	12.7%
32,402,347	32,097,908	(304,439)	(0.9%)	Professional Claims	234,964,376	219,807,592	(15,156,784)	(6.9%)
36,459,241	43,308,516	6,849,275	15.8%	MLTSS	298,355,675	296,887,164	(1,468,511)	(0.5%)
(921,317)	-	921,317	0.0%	Prescription Drugs	346,001,025	345,521,586	(479,439)	(0.1%)
5,262,986	5,277,937	14,951	0.3%	Medical Management	30,637,511	37,259,379	6,621,868	17.8%
1,736,044	3,288,535	1,552,491	47.2%	Reinsurance & Other	149,025,712	7,492,632	(141,533,080)	(1889.0%)
227,928,200	**240,412,398**	**12,484,198**	**5.2%**	**Total Medical Expenses**	**2,200,656,299**	**2,000,804,611**	**(199,851,688)**	**(10.0%)**
23,750,641	**4,283,800**	**19,466,841**	**454.4%**	**Gross Margin**	**154,267,638**	**34,609,364**	**119,658,274**	**345.7%**
				Administrative Expenses				
7,379,811	8,166,758	786,947	9.6%	Salaries, wages & employee benefits	49,686,037	57,521,078	7,835,041	13.6%
504,473	725,618	221,145	30.5%	Professional fees	1,808,114	4,290,438	2,482,324	57.9%
1,003,028	977,195	(25,833)	(2.6%)	Purchased services	6,937,455	7,934,615	997,160	12.6%
364,536	383,828	19,292	5.0%	Printing and postage	2,274,397	2,686,796	412,399	15.3%
356,506	492,500	135,994	27.6%	Depreciation and amortization	2,665,223	3,447,500	782,277	22.7%
1,506,153	2,024,053	517,900	25.6%	Other operating expenses	10,926,559	12,872,735	1,946,176	15.1%
(227,402)	(301,871)	(74,469)	(24.7%)	Indirect Cost Allocation, Occupancy Expense	(1,649,320)	(2,083,793)	(434,473)	(20.9%)
10,887,105	**12,468,081**	**1,580,976**	**12.7%**	**Total Administrative Expenses**	**72,648,464**	**86,669,369**	**14,020,905**	**16.2%**
				Operating Tax				
15,398,154	13,913,205	1,484,949	10.7%	Tax Revenue	100,450,336	97,250,791	3,199,545	3.3%
13,854,167	13,913,205	59,038	0.4%	Premium Tax Expense	96,979,167	97,250,791	271,624	0.3%
1,543,987	**-**	**(1,543,987)**	**0.0%**	**Total Operating Tax**	**3,471,169**	**-**	**(3,471,169)**	**0.0%**
85	-	**85**	**0.0%**	**Other Income**	8,801	-	**8,801**	**0.0%**
14,407,608	**(8,184,281)**	**22,591,889**	**276.0%**	**Change in Net Assets**	**85,099,144**	**(52,060,005)**	**137,159,149**	**263.5%**
90.6%	***98.2%***	***7.7%***	***7.8%***	***Medical Loss Ratio***	***93.4%***	***98.3%***	***4.9%***	***4.9%***
4.3%	***5.1%***	***0.8%***	***15.1%***	***Admin Loss Ratio***	***3.1%***	***4.3%***	***1.2%***	***27.6%***

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MEDI-CAL INCOME STATEMENT– JANUARY MONTH:

REVENUES of $251.7 million are favorable to budget $7.0 million driven by:

- Favorable volume related variance of $10.7 million
- Unfavorable price related variance of $3.7 million
  - $24.7 million due to Calendar Year (CY) 2022 rate update, prior year retroactive eligibility changes, and Proposition 56 estimates
  - Offset by $27.5 million due to COVID-19 risk corridor

MEDICAL EXPENSES of $227.9 million are favorable to budget $12.5 million driven by:

- Unfavorable volume related variance of $10.5 million
- Favorable price related variance of $23.0 million
  - Facilities Claims expense favorable variance of $9.6 million due to deferred and delayed services
  - Managed Long Term Services and Supports (MLTSS) expense favorable variance of $8.7 million due to Incurred But Not Reported (IBNR) claims
  - Reinsurance & Other expense favorable variance of $1.7 million
  - Professional Claims expense favorable variance of $1.1 million
  - Prescription Drugs expense favorable variance of $0.9 million
  - Provider Capitation expense favorable variance of $0.7 million

ADMINISTRATIVE EXPENSES of $10.9 million are favorable to budget $1.6 million driven by:

- Salaries & Benefit expense favorable to budget $0.8 million
- Other Non-Salary expense favorable to budget $0.8 million

CHANGE IN NET ASSETS is $14.4 million, favorable to budget $22.6 million

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CalOptima
OneCare Connect Total
Statement of Revenue and Expenses
For the Seven Months Ending January 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,686	**15,179**	**(493)**	**(3.2%)**	**Member Months**	**103,653**	**105,630**	**(1,977)**	**(1.9%)**
				Revenues				
2,606,268	2,804,240	(197,972)	(7.1%)	Medi-Cal Capitation Revenue	19,265,633	19,655,002	(389,369)	(2.0%)
18,715,521	20,625,421	(1,909,900)	(9.3%)	Medicare Capitation Revenue Part C	129,667,892	134,891,978	(5,224,086)	(3.9%)
6,052,797	5,818,381	234,416	4.0%	Medicare Capitation Revenue Part D	41,786,629	40,090,829	1,695,800	4.2%
-	-	-	0.0%	Other Income	-	-	-	0.0%
27,374,586	**29,248,042**	**(1,873,456)**	**(6.4%)**	**Total Operating Revenue**	**190,720,155**	**194,637,809**	**(3,917,654)**	**(2.0%)**
				Medical Expenses				
10,991,434	12,610,850	1,619,416	12.8%	Provider Capitation	76,841,378	81,368,156	4,526,778	5.6%
4,005,574	4,558,861	553,287	12.1%	Facilities Claims	27,914,155	30,461,651	2,547,496	8.4%
1,012,801	1,088,447	75,646	6.9%	Ancillary	7,739,535	7,319,552	(419,983)	(5.7%)
1,429,101	1,443,360	14,259	1.0%	MLTSS	10,026,501	10,107,365	80,864	0.8%
5,879,474	6,808,469	928,995	13.6%	Prescription Drugs	42,942,475	46,013,759	3,071,284	6.7%
1,088,188	1,235,094	146,907	11.9%	Medical Management	7,192,711	8,598,998	1,406,287	16.4%
93,415	182,537	89,122	48.8%	Other Medical Expenses	1,331,857	1,245,593	(86,264)	(6.9%)
24,499,988	**27,927,618**	**3,427,630**	**12.3%**	**Total Medical Expenses**	**173,988,611**	**185,115,074**	**11,126,463**	**6.0%**
2,874,598	**1,320,424**	**1,554,174**	**117.7%**	**Gross Margin**	**16,731,543**	**9,522,735**	**7,208,808**	**75.7%**
				Administrative Expenses				
700,365	866,998	166,633	19.2%	Salaries, Wages & Employee Benefits	5,100,802	6,129,442	1,028,640	16.8%
4,575	104,320	99,745	95.6%	Professional Fees	174,156	342,390	168,234	49.1%
164,603	119,752	(44,851)	(37.5%)	Purchased Services	756,141	782,549	26,408	3.4%
177,340	138,109	(39,231)	(28.4%)	Printing and Postage	649,391	966,763	317,372	32.8%
941	21,075	20,134	95.5%	Other Operating Expenses	7,191	147,525	140,334	95.1%
552,533	680,053	127,520	18.8%	Indirect Cost Allocation	3,867,729	4,760,371	892,642	18.8%
1,600,357	**1,930,307**	**329,950**	**17.1%**	**Total Administrative Expenses**	**10,555,410**	**13,129,040**	**2,573,630**	**19.6%**
1,274,241	**(609,883)**	**1,884,124**	**308.9%**	**Change in Net Assets**	**6,176,133**	**(3,606,305)**	**9,782,438**	**271.3%**
89.5%	***95.5%***	***6.0%***	***6.3%***	***Medical Loss Ratio***	***91.2%***	***95.1%***	***3.9%***	***4.1%***
5.8%	***6.6%***	***0.8%***	***11.4%***	***Admin Loss Ratio***	***5.5%***	***6.7%***	***1.2%***	***18.0%***

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ONECARE CONNECT INCOME STATEMENT– JANUARY MONTH:

REVENUES of $27.4 million are unfavorable to budget $1.9 million driven by:

- Unfavorable volume related variance of $0.9 million
- Unfavorable price related variance of $0.9 million

MEDICAL EXPENSES of $24.5 million are favorable to budget $3.4 million driven by:

- Favorable volume related variance of $0.9 million
- Favorable price related variance of $2.5 million
  - Provider Capitation expense favorable variance of $1.2 million
  - Prescription Drugs expense favorable variance of $0.7 million
  - Facilities Claims expense favorable variance of $0.4 million

ADMINISTRATIVE EXPENSES of $1.6 million are favorable to budget $0.3 million

CHANGE IN NET ASSETS is $1.3 million, favorable to budget $1.9 million

CalOptima
OneCare
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
2,319	**1,787**	**532**	**29.8%**	**Member Months**	**15,436**	**12,411**	**3,025**	**24.4%**
				Revenues				
1,970,616	1,476,592	494,024	33.5%	Medicare Part C revenue	13,313,062	9,865,520	3,447,542	34.9%
594,387	719,228	(124,841)	(17.4%)	Medicare Part D revenue	6,547,086	4,534,860	2,012,226	44.4%
2,565,003	**2,195,820**	**369,183**	**16.8%**	**Total Operating Revenue**	**19,860,148**	**14,400,380**	**5,459,768**	**37.9%**
				Medical Expenses				
793,370	585,031	(208,339)	(35.6%)	Provider Capitation	5,426,088	3,843,017	(1,583,071)	(41.2%)
979,399	639,275	(340,124)	(53.2%)	Inpatient	6,125,528	4,252,002	(1,873,526)	(44.1%)
120,725	76,244	(44,481)	(58.3%)	Ancillary	727,275	508,037	(219,238)	(43.2%)
7,405	29,816	22,411	75.2%	Skilled Nursing Facilities	384,145	206,774	(177,371)	(85.8%)
868,759	704,486	(164,273)	(23.3%)	Prescription Drugs	6,358,111	4,769,484	(1,588,627)	(33.3%)
59,261	51,095	(8,166)	(16.0%)	Medical Management	259,929	355,579	95,650	26.9%
4,175	1,322	(2,853)	(215.8%)	Other Medical Expenses	24,719	9,183	(15,536)	(169.2%)
2,833,095	**2,087,269**	**(745,826)**	**(35.7%)**	**Total Medical Expenses**	**19,305,795**	**13,944,076**	**(5,361,719)**	**(38.5%)**
(268,092)	**108,551**	**(376,643)**	**(347.0%)**	**Gross Margin**	**554,353**	**456,304**	**98,049**	**21.5%**
				Administrative Expenses				
78,623	72,718	(5,905)	(8.1%)	Salaries, wages & employee benefits	535,030	513,207	(21,823)	(4.3%)
29,167	29,166	(1)	(0.0%)	Professional fees	210,932	204,162	(6,770)	(3.3%)
12,164	9,167	(2,997)	(32.7%)	Purchased services	77,807	64,169	(13,638)	(21.3%)
2,741	15,823	13,082	82.7%	Printing and postage	67,504	110,761	43,257	39.1%
461	1,029	568	55.2%	Other operating expenses	1,076	7,203	6,127	85.1%
58,503	50,924	(7,579)	(14.9%)	Indirect cost allocation, occupancy expens	409,518	356,468	(53,050)	(14.9%)
181,659	**178,827**	**(2,832)**	**(1.6%)**	**Total Administrative Expenses**	**1,301,866**	**1,255,970**	**(45,896)**	**(3.7%)**
(449,751)	**(70,276)**	**(379,475)**	**(540.0%)**	**Change in Net Assets**	**(747,513)**	**(799,666)**	**52,153**	**6.5%**
110.5%	***95.1%***	***(15.4%)***	***(16.2%)***	***Medical Loss Ratio***	***97.2%***	***96.8%***	***(0.4%)***	***(0.4%)***
7.1%	***8.1%***	***1.1%***	***13.0%***	***Admin Loss Ratio***	***6.6%***	***8.7%***	***2.2%***	***24.8%***

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CalOptima
PACE
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
427	**412**	**15**	**3.6%**	**Member Months**	**2,898**	**2,812**	**86**	**3.1%**
				Revenues				
2,690,855	2,542,917	147,938	5.8%	Medi-Cal Capitation Revenue	17,846,106	17,458,473	387,633	2.2%
663,399	659,795	3,604	0.5%	Medicare Part C Revenue	4,230,132	4,331,729	(101,597)	(2.3%)
141,202	148,630	(7,428)	(5.0%)	Medicare Part D Revenue	1,367,547	1,023,462	344,085	33.6%
3,495,456	**3,351,342**	**144,114**	**4.3%**	**Total Operating Revenue**	**23,443,785**	**22,813,664**	**630,121**	**2.8%**
				Medical Expenses				
912,122	1,020,927	108,805	10.7%	Medical Management	5,767,919	6,968,079	1,200,160	17.2%
759,147	759,013	(134)	(0.0%)	Facilities Claims	4,848,950	5,109,263	260,313	5.1%
1,194,007	694,815	(499,192)	(71.8%)	Professional Claims	5,636,450	4,642,044	(994,406)	(21.4%)
126,193	188,169	61,976	32.9%	Patient Transportation	838,216	1,016,581	178,365	17.5%
297,056	339,711	42,655	12.6%	Prescription Drugs	2,224,807	2,250,839	26,032	1.2%
23,141	52,824	29,683	56.2%	MLTSS	356,257	288,586	(67,671)	(23.4%)
5,338	5,191	(147)	(2.8%)	Other Expenses	36,225	35,106	(1,119)	(3.2%)
3,317,003	**3,060,650**	**(256,353)**	**(8.4%)**	**Total Medical Expenses**	**19,708,824**	**20,310,498**	**601,674**	**3.0%**
178,453	**290,692**	**(112,239)**	**-38.6%**	**Gross Margin**	**3,734,961**	**2,503,166**	**1,231,795**	**49.2%**
				Administrative Expenses				
108,727	155,130	46,403	29.9%	Salaries, wages & employee benefits	791,121	1,063,643	272,522	25.6%
1,355	167	(1,188)	(711.1%)	Professional fees	7,251	1,169	(6,082)	(520.3%)
47,803	40,925	(6,878)	(16.8%)	Purchased services	98,158	286,475	188,317	65.7%
25,901	19,238	(6,663)	(34.6%)	Printing and postage	95,615	134,666	39,051	29.0%
356	400	44	11.0%	Depreciation & amortization	6,403	2,800	(3,603)	(128.7%)
2,742	17,166	14,424	84.0%	Other operating expenses	42,569	55,877	13,308	23.8%
11,506	4,944	(6,562)	(132.7%)	Indirect Cost Allocation, Occupancy Expense	65,630	34,608	(31,022)	(89.6%)
198,389	**237,970**	**39,581**	**16.6%**	**Total Administrative Expenses**	**1,106,748**	**1,579,238**	**472,490**	**29.9%**
				Operating Tax				
6,337	-	6,337	0.0%	Tax Revenue	43,006	-	43,006	0.0%
6,337	-	(6,337)	0.0%	Premium Tax Expense	43,006	-	(43,006)	0.0%
-	-	-	**0.0%**	**Total Net Operating Tax**	-	-	-	**0.0%**
(19,936)	**52,722**	**(72,658)**	**(137.8%)**	**Change in Net Assets**	**2,628,213**	**923,928**	**1,704,285**	**184.5%**
94.9%	***91.3%***	***(3.6%)***	***(3.9%)***	***Medical Loss Ratio***	***84.1%***	***89.0%***	***5.0%***	***5.6%***
5.7%	***7.1%***	***1.4%***	***20.1%***	***Admin Loss Ratio***	***4.7%***	***6.9%***	***2.2%***	***31.8%***

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CalOptima
Multipurpose Senior Services Program
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2022

Month					Year to Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
452	**455**	**(3)**	**(0.7%)**	**Member Months**	**452**	**455**	**(3)**	**(0.7%)**
				Revenues				
219,134	203,090	16,044	7.9%	Capitation Revenue	219,134	203,090	16,044	7.9%
219,134	**203,090**	**16,044**	**7.9%**	**Total Operating Revenue**	**219,134**	**203,090**	**16,044**	**7.9%**
				Medical Expenses				
123,622	118,471	(5,151)	(4.3%)	Medical Management	123,622	118,471	(5,151)	(4.3%)
				Waived Services				
233	120	(113)	(94.2%)	Minor home repairs	233	120	(113)	(94.2%)
7,260	7,505	245	3.3%	Non-medical home equipment	7,260	7,505	245	3.3%
3,962	3,052	(910)	(29.8%)	Chores	3,962	3,052	(910)	(29.8%)
6,356	2,615	(3,741)	(143.1%)	Personal care	6,356	2,615	(3,741)	(143.1%)
514	400	(114)	(28.4%)	In-home respite	514	400	(114)	(28.4%)
412	644	232	36.1%	Transportation	412	644	232	36.1%
514	961	447	46.6%	Home delivered meals	514	961	447	46.6%
(69)	152	221	145.1%	Food	(69)	152	221	145.1%
9,231	10,118	887	8.8%	Communications	9,231	10,118	887	8.8%
25	835	810	97.0%	Non-Covered Services	25	835	810	97.0%
123,622	118,471	(5,151)	(4.3%)	Total Medical Management	123,622	118,471	(5,151)	(4.3%)
28,436	26,402	(2,034)	(7.7%)	Other Medical Expenses	28,436	26,402	(2,034)	(7.7%)
152,058	**144,873**	**(7,185)**	**(5.0%)**	**Total Program Expenses**	**152,058**	**144,873**	**(7,185)**	**(5.0%)**
67,075	**58,217**	**8,858**	**15.2%**	**Gross Margin**	**67,075**	**58,217**	**8,858**	**15.2%**
				Administrative Expenses				
55,923	58,151	2,228	3.8%	Salaries, wages & employee benefits	55,923	58,151	2,228	3.8%
710	1,125	416	36.9%	Professional fees	710	1,125	416	36.9%
6,154	7,309	1,155	15.8%	Other operating expenses	6,154	7,309	1,155	15.8%
4,119	4,884	765	15.7%	Indirect Cost Allocation	4,119	4,884	765	15.7%
66,906	**71,469**	**4,563**	**6.4%**	**Total Administrative Expenses**	**66,906**	**71,469**	**4,563**	**6.4%**
170	**(13,252)**	**13,422**	**101.3%**	**Change in Net Assets**	**170**	**(13,252)**	**13,422**	**101.3%**
69.4%	***71.3%***	***1.9%***	***2.7%***	***Medical Loss Ratio***	***69.4%***	***71.3%***	***1.9%***	***2.7%***
30.5%	***35.2%***	***4.7%***	***13.2%***	***Admin Loss Ratio***	***30.5%***	***35.2%***	***4.7%***	***13.2%***

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CalOptima
BUILDING 505 - CITY PARKWAY
Statement of Revenues and Expenses
For the Seven Months Ending January 31, 2022

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				
38,080	54,250	16,170	29.8%	Purchase services	262,853	379,750	116,897	30.8%
174,242	206,000	31,758	15.4%	Depreciation & amortization	1,208,852	1,442,000	233,148	16.2%
19,565	19,750	185	0.9%	Insurance expense	136,954	138,250	1,296	0.9%
130,542	131,583	1,041	0.8%	Repair and maintenance	762,485	921,081	158,596	17.2%
25,136	43,000	17,864	41.5%	Other Operating Expense	357,381	301,000	(56,381)	(18.7%)
(387,564)	(454,583)	(67,019)	(14.7%)	Indirect allocation, Occupancy	(2,728,525)	(3,182,081)	(453,556)	(14.3%)
-	-	-	**0.0%**	**Total Administrative Expenses**	-	-	-	**0.0%**
-	-	-	**0.0%**	**Change in Net Assets**	-	-	-	**0.0%**

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OTHER INCOME STATEMENTS – JANUARY MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($0.4) million, unfavorable to budget $0.4 million

PACE INCOME STATEMENT

CHANGE IN NET ASSETS is ($19,936), unfavorable to budget $72,658

MSSP INCOME STATEMENT

CHANGE IN NET ASSETS is $170, favorable to budget $13,422

- Carved out of Medi-Cal effective January 1, 2022

NET INVESTMENT INCOME

- Unfavorable variance of $5.0 million is primarily driven by unrealized losses in bond value due to an earlier than expected interest rate increase by the Federal Reserve

CalOptima
Balance Sheet
January 31, 2022

ASSETS		LIABILITIES & NET POSITION	
Current Assets		**Current Liabilities**	
Operating Cash	$763,869,915	Accounts Payable	$22,131,513
Short-term Investments	954,632,769	Medical Claims liability	962,778,097
Capitation receivable	162,280,879	Accrued Payroll Liabilities	12,287,670
Receivables - Other	41,917,744	Deferred Revenue	9,750,821
Prepaid expenses	15,154,070	Deferred Lease Obligations	109,958
		Capitation and Withholds	168,727,670
Total Current Assets	**1,937,855,376**	**Total Current Liabilities**	**1,175,785,728**
Capital Assets			
Furniture & Equipment	46,251,085		
Building/Leasehold Improvements	7,714,655		
505 City Parkway West	52,168,012		
	106,133,752		
Less: accumulated depreciation	(61,573,526)		
Capital assets, net	44,560,226	Other (than pensions) post employment benefits liability	31,956,845
Other Assets		Net Pension Liabilities	30,384,981
Restricted Deposit & Other	300,000	Bldg 505 Development Rights	-
Homeless Health Reserve	56,798,913		
Board-designated assets:		**TOTAL LIABILITIES**	**1,238,127,554**
Cash and Cash Equivalents	4,050,633		
Investments	579,120,317	**Deferred Inflows**	
Total Board-designated Assets	583,170,950	Excess Earnings	344,198
		OPEB 75 Difference in Experience	536,000
Total Other Assets	640,269,863	Change in Assumptions	2,709,945
		OPEB Changes in Assumptions	773,000
		Net Position	
TOTAL ASSETS	**2,622,685,465**	TNE	106,628,967
Deferred Outflows		Funds in Excess of TNE	1,288,558,098
Contributions	1,508,025	**TOTAL NET POSITION**	1,395,187,065
Difference in Experience	3,236,721		
Excess Earning	2,104,780		
Changes in Assumptions	3,692,771		
OPEB 75 Changes in Assumptions	3,906,000		
Pension Contributions	544,000		
TOTAL ASSETS & DEFERRED OUTFLOWS	**2,637,677,762**	**TOTAL LIABILITIES, DEFERRED INFLOWS & NET POSITION**	**2,637,677,762**

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CalOptima
Board Designated Reserve and TNE Analysis
as of January 31, 2022

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	239,062,207				
	Tier 1 - MetLife	237,950,240				
Board-designated Reserve		477,012,447	377,095,460	584,405,929	99,916,987	(107,393,482)
	Tier 2 - Payden & Rygel	53,105,626				
	Tier 2 - MetLife	53,052,876				
TNE Requirement		106,158,503	106,628,967	106,628,967	(470,465)	(470,465)
	Consolidated:	**583,170,949**	**483,724,428**	**691,034,896**	**99,446,522**	**(107,863,947)**
	Current reserve level	*1.69*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
January 31, 2022

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	11,093,408	86,406,272
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	531,104	3,880,479
Changes in assets and liabilities:		
Prepaid expenses and other	(2,858,932)	(3,175,459)
Catastrophic reserves		
Capitation receivable	66,151,078	270,697,396
Medical claims liability	169,724,528	18,459,149
Deferred revenue	240,311	(3,836,005)
Payable to health networks	(5,522,875)	23,947,881
Accounts payable	(27,074,631)	(24,282,908)
Accrued payroll	(2,740,709)	(3,817,429)
Other accrued liabilities	(14,504)	(17,370)
Net cash provided by/(used in) operating activities	209,528,778	368,262,005
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	848,674	110,777,038
Change in Property and Equipment	(495,615)	(2,712,829)
Change in Board designated reserves	3,549,937	5,709,203
Change in Homeless Health Reserve	-	-
Net cash provided by/(used in) investing activities	3,902,997	113,773,411
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	213,431,775	482,035,416
CASH AND CASH EQUIVALENTS, beginning of period	$550,438,140	281,834,499
CASH AND CASH EQUIVALENTS, end of period	**763,869,915**	**763,869,915**

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BALANCE SHEET – JANUARY MONTH:

ASSETS of $2.6 billion increased $145.7 million from December or 5.8%

- Operating Cash and Short-term Investments net increase of $212.6 million due to the receipt of the Hospital Quality Assurance Fee (HQAF) of $146.4 million, along with the timing of capitation receipts
  - Operating cash increased $213.4 million
  - Short-term Investments decreased $0.8 million
- Capitation Receivables decreased $43.4 million due to the timing of cash receipts
- Receivables – Other decreased $22.7 million due to the receipt from the Centers for Medicare & Medicaid Services (CMS) for the CY 2020 Part D prescription reconciliation
- Board-Designated Assets decreased $3.5 million

LIABILITIES of $1.2 billion increased $134.6 million from December or 12.2%

- Claims Liabilities increased $169.7 million due to timing of HQAF payment and IBNR
- Accounts Payable decreased $27.1 million due to the timing of accruals for the quarterly premium tax payment
- Capitation and Withhold decreased $5.5 million due to timing of capitation payments
- Accrued Payroll Liabilities decreased $2.9 million due to timing of employee pay period payments

NET ASSETS of $1.4 billion, increased $11.1 million from December or 0.8%

Summary of Homeless Health Initiatives and Allocated Funds
As of January 31, 2022

			Amount
Program Commitment		**$**	**100,000,000**
Funds Allocation, approved initiatives:			
Enhanced Medi-Cal Services at the Be Well OC Regional Mental Health and Wellness Campus	11,400,000		
Recuperative Care	8,250,000		
Medical Respite	250,000		
Day Habilitation (County for HomeKey)	2,500,000		
Clinical Field Team Start-up & Federal Qualified Health Center (FQHC)	1,600,000		
CalOptima Homeless Response Team	6,000,000		
Homeless Coordination at Hospitals	10,000,000		
CalOptima Days & QI Program - Homeless Clinic Access Program or HCAP	1,231,087		
FQHC (Community Health Center) Expansion and HHI Support	570,000		
HCAP Expansion for Telehealth and CFT On Call Days	1,000,000		
Vaccination Intervention and Member Incentive Strategy	400,000		
Funds Allocation Total		**$**	**43,201,087**
Program Commitment Balance, available for new initiatives*		**$**	**56,798,913**

On June 27, 2019 at a Special Board meeting, the Board approved four funding categories.

This report only lists Board approved projects.

* Funding sources of the remaining balance are IGT8 and CalOptima's operating income, which must be used for Medi-Cal covered services for the Medi-Cal population

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Budget Allocation Changes
Reporting Changes for January 2022

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
August	Medi-Cal	Ground Floor Corridor Heating and Cooling Boxes Replacement	Multiple Bathroom Upgrades (Original Bathrooms on 2nd and 4th Floors)	$25,800	To transfer funds from capital project Ground Floor Corridor Heating and Cooling Boxes Replacement to capital project Multiple Bathroom Upgrades (Original Bathrooms on the 2nd and 4th Floors) to fund the final bathroom change order.	2020-21
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Citrix Virtual Servers to Support Version - Hardware	$24,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Citrix Virtual Servers to Support Version to provide additional funds for hardware purchases.	2021-22
November	Medi-Cal	Upgrade the System Backup Application Disk Storage - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$51,000	To transfer funds from capital project Upgrade the System Backup Application Disk Storage to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW - BMC	Maintenance HW/SW – SolarWinds	$10,500	To repurpose funds from BMC to SolarWinds to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Upgrade the Citrix Virtual Servers to Support Version - Hardware	Upgrade the Database Disk Storage Equipment - Hardware	$13,500	To transfer funds from capital project Upgrade the Citrix Virtual Servers to Support Version to capital project Upgrade the Database Disk Storage Equipment to provide additional funds for hardware purchases.	2021-22
December	Medi-Cal	Maintenance HW/SW – Optum/Ingenix ICD 10	Maintenance HW/SW – Smart Communications	$14,000	To repurpose funds from Optum/Ingenix ICD10 to Smart Communications to provide additional funds for maintenance contract renewal.	2021-22
December	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – Extreme Networks	$24,000	To repurpose funds from Microsoft True-UP to Extreme Networks to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Professional Fees – Citrix Pro Fees	Professional Fees – HIPPA Compliance (Risk Assessment & Network Penetration)	$10,500	To repurpose funds from Citrix professional fees to HIPPAA Compliance professional fees to provide additional funds.	2021-22
January	Medi-Cal	Maintenance HW/SW – Microsoft True-Up	Maintenance HW/SW – SSL Certs for Production Applications	$12,000	To repurpose funds from Microsoft True-UP to SSL Certs for Production Applications to provide additional funds for maintenance contract renewal.	2021-22
January	Medi-Cal	Purchased Services – Executive Coaching	Purchased Services – Concentra	$18,000	To reallocate funding from Executive Coaching to Concentra for additional funds needed.	2021-22

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Board of Directors Meeting
March 3, 2022

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors including, but not limited to, updates on internal and health network monitoring and 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

- 2022 Medicare Parts C and D Data Validation Audit (*applicable to OneCare and OneCare Connect*):

  On an annual basis, CMS requires all plan sponsors to engage an independent auditor to validate all Medicare Parts C and D data reported for the prior calendar year. CalOptima has requested the required Parts C and D reporting data from all impacted business areas to ensure the accuracy of the data prior to submission in February 2022. The validation audit is expected to take place starting in March and conclude in June 2022. The audit includes a webinar validation and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (IDUR) Controls

  CalOptima departments are working to review the reported data for each area for regulatory submissions by the CMS submission deadlines of February 7, 2022, and February 28, 2022.

- 2021 CMS Program Audit (applicable to OneCare and OneCare Connect):

  CMS conducted a program audit on both OneCare and OneCare Connect. CMS released the preliminary draft audit report on 8/6/21 and completed the exit conference. On October 21, 2021, CMS issued the Draft Audit Report, which noted a total of 11 observations, 8 Corrective Action Required (CARs), and one ICAR. (The ICAR issued on August 27th and the CAP was accepted by CMS on 9/13/21.) As there were no comments/rebuttals to the

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Draft Audit Report, CMS released the Final Audit Report, with no changes to the findings, on 11/5/21.

The following table provides a high-level summary of the audit findings by program area:

2021 CMS Program Audit Final Report Summary			
Overall Final Audit Score – 0.59			
	Immediate Corrective Action Required	**Corrective Action Required**	**Observations**
CPE [1] *[OC; OCC]*	0	0	0
FA [2] *[OC; OCC]*	0	1	1
CDAG [3] *[OC; OCC]*	0	0	1
ODAG [4] *[OC]*	1	0	4
SNP-MOC [5] *[OC]*	0	2	1
SARAG [6] *[OCC]*	0	0	4
CCQIPE [7] *[OCC]*	0	5	0
Total:	**1**	**8**	**11**

[1] CPE = Compliance Program Effectiveness
[2] FA = Formulary Administration
[3] CDAG = Coverage Determinations, Appeals and Grievances
[4] ODAG = Organization Determinations, Appeals & Grievances
[5] SNP-MOC = Special Needs Plan – Model of Care
[6] SARAG = Service Authorization Requests, Appeals, and Grievances
[7] CCQIPE = Care Coordination and Quality Improvement Effectiveness

CalOptima submitted the corrective action plans (CAPs) for the non-ICAR condition on 12/9/21. On 1/5/22, CMS informed CalOptima that the CAPs submitted for the SNP, CCQIPE and FA program areas have been accepted. In terms of next steps, CMS has provided a deadline of 7/5/2022 for CalOptima to complete the independent validation audit (IVA).

CalOptima has chosen Integritas Medicare to conduct the IVA and will be working with BluePeak to conduct a mock validation audit ahead of the IVA. CalOptima is currently working with the vendor to finalize the IVA workplan in order to submit to CMS for review and approval.

2. OneCare Connect

- CY 2020 Medicare Part C Improper Payment Measure (Part C IPM)

On 12/17/21, CMS informed CalOptima that its OneCare Connect program was selected to participate in the CY 2020 Medicare Part C IPM (formerly known as NAT20 RADV). CMS conducts Medicare Part C IPM activity to calculate a program wide improper payment rate for Medicare Part C.

On 1/19/22, CMS hosted a training teleconference for this activity.

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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On 1/20/22, CMS released the enrollee list which contained nineteen (19) CMS-HCC's for which medical records will need to be collected for submission to CMS. The internal deadline for this activity is 5/5/22.

On 1/20/22, CMS encouraged plans to submit records early in the submission window to take advantage of the Interim Findings Reports (IFRs). IFRs provide preliminary feedback on medical record review results for all medical record submissions received as of the cutoff date. CMS plans to release two IFRs during the March and April timeframes. CMS anticipates releasing the IFRs approximately two weeks following the cutoff dates. The IFR submission cutoff dates are as follows:

- IFR #1 Submission Cutoff Date: Thursday, February 24, 2022 at 11:59 p.m. PT
- IFR #2 Submission Cutoff Date: Thursday, March 31, 2022 at 11:59 p.m. PT

3. Medi-Cal

- 2021 DHCS Medical Audit:

On October 7, 2021, DHCS formally engaged CalOptima for its annual 2021 DHCS Medical Audit. The audit covered CalOptima's provision of Medi-Cal services to its non-Seniors and Persons with Disabilities (non-SPD) and SPD members. This year, due to the COVID-19 health emergency, DHCS hosted its audit via webinar from January 24, 2022 through February 4, 2022. The Entrance Conference was held on January 24, 2022.

The 2021 DHCS Medical Audit covered the review period of February 1, 2020 - December 31, 2021 and assessed CalOptima's compliance with its Medi-Cal contract and regulations in the areas of utilization management, case management and coordination of care, member's rights, quality management, access & availability, and administrative and organizational capacity. DHCS reviewed Kaiser's delegated functions, including Prior Authorization, Appeals, Call Inquiries, Exempt Grievances, and standard Grievances, as well as examined CalOptima's oversight of Kaiser.

Additionally, the audit scope included a review of post-stabilization authorizations (PSA). For this review, DHCS selected two (2) health networks (Prospect and FCMG) for review, along with CalOptima. DHCS attempted to review this scope as part of an ad-hoc review in 2020 and was unable to complete it due to the COVID-19 health emergency. CalOptima was informed that PSA would be included in the 2021 DHCS Medical Audit scope.

On February 4, 2022, DHCS concluded the webinar portion of the 2021 DHCS Medical Audit. Over the next several weeks, DHCS will complete its desktop review and finalize the draft findings report. DHCS intends to host an Exit Conference in April 2022 to review CalOptima's draft audit findings. At that time, the draft findings report will also be provided for CalOptima's review. CalOptima will have 15 calendar days to confirm or rebut the draft findings. DHCS will provide CalOptima with a final audit report and formal request for corrective action, 30 calendar days from the Exit Conference (slated for May 2022).

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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B. Regulatory Notices of Non-Compliance

- CalOptima did not receive any notices of non-compliance from its regulators for the month of January 2022.

C. Updates on Internal and Health Network Monitoring and Audits

1. Internal Monitoring Dashboard:

- As part of its monitoring process, CalOptima's Audit & Oversight department, in collaboration with business areas, maintains a dashboard to monitor key performance metrics for internal and external operations on a monthly basis. Dashboard results are presented to CalOptima's Audit & Oversight Committee and Compliance Committee for oversight. Below are the dashboard results.

- **Requirement: Standard Service Authorization Requests (MSSAR) Processed ≤ 5 Business Days after receipt of information reasonably necessary to make a decision but no later than ≤ 14 Calendar Days from receipt of request.**

Internal Goal	Oct.	Nov.	Dec.
98%	97.76%	97.60%	97.23%

  - CalOptima's Audit & Oversight (A&O) department has issued a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

- **Requirement: Standard Pre-Service Organization Determinations (SOD) Processed ≤ 14 Calendar Days from Receipt of Request**

Internal Goal	Oct.	Nov.	Dec.
98%	40%	73.33%	50%

  - OneCare Utilization Management metrics for Timely Standard Pre-Service Organization Determination identified three (3) consecutive months of falling below compliance goal.
  - CalOptima's Audit & Oversight (A&O) department has issued a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

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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- **Requirement: Standard Service Authorization Requests (MSSAR) Processed ≤ 5 Business Days after receipt of information reasonably necessary to make a decision but no later than ≤ 14 Calendar Days from receipt of request.**

Internal Goal	Oct.	Nov.	Dec.
98%	51.19 %	58.92%	93.70%

  - CalOptima's Audit & Oversight (A&O) department has issued a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

- **Requirement: Medi-Cal Provider Data Management Services metrics for ACT Resolved within ≤ 5 Business Days of receipt**

Internal Goal	Oct.	Nov.	Dec.
98%	92.5 %	74%	80.15%

  - Medi-Cal metrics for ACT identified three (3) consecutive months of falling below compliance goal.
  - CalOptima's Audit & Oversight (A&O) department has issued a request for a corrective action plan (CAP) for deficiencies identified. The A&O department continues to work with the impacted department to remediate the deficiencies by identifying accurate root causes and implementing quality controls to ensure sustained compliance.

2. Internal Monitoring: Medi-Cal[a\]

- Medi-Cal GARS: Standard Appeals -Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Timely Effectuation	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
September 2021	100%	94%	100%	100%	26%	N/A	100%
October 2021	100%	94%	100%	100%	82%	88%	100%
November 2021	100%	100%	100%	100%	100%	89%	100%

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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- Based on a focused review of nine (9) Medi-Cal standard appeals for November 2021, the lower compliance score of 89% for timely effectuation was due to one (1) untimely effectuation case.

- Medi-Cal GARS: Expedited Appeals Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Expedited Appeals Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Clinical Decision Making	Timely Effectuation	Member Notice Content	Resolution of Expedited Appeals within 72 Hours of Receipt
September 2021	100%	N/A	100%	100%	N/A	0%	100%
October 2021	100%	N/A	100%	100%	66%	100%	100%
November 2021	100%	N/A	100%	100%	67%	100%	100%

- Based on a focused review of three (3) Medi-Cal expedited appeals for November 2021, the lower compliance score of 67% for timely effectuation was due to one (1) untimely effectuation case.

- Medi-Cal GARS: Standard Grievances Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Grievances Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Standard Resolution of Grievances within ≤ 30 Calendar Days of Receipt
September 2021	100%	100%	100%	94%	100%
October 2021	100%	100%	100%	76%	100%
November 2021	100%	100%	100%	81%	100%

- Based on a focused review of sixteen (16) Medi-Cal standard grievances for November 2021, the lower compliance score of 81 % for member notice content was due to three (3) files exceeding the sixth (6^{th}) grade reading level.

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 GARS: Expedited Grievances Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
September 2021	100%	100%	100%	50%	100%
October 2021	100%	100%	100%	67%	100%
November 2021	100%	100%	100%	50%	100%

  - Based on a focused review of four (4) Medi-Cal expedited grievances for November 2021, the lower compliance score of 50% for member notice content was due to two (2) files exceeding the sixth (6^{th}) grade reading level.
- Medi-Cal Utilization Management: Standard Prior Authorizations Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
September 2021	100%	0%	100%	100%	100%	100%
October 2021	100%	10%	100%	100%	100%	83%
November 2021	100%	67%	100%	100%	100%	100%

  - Based on a focused review of six (6) Medi-Cal standard prior authorizations for November 2021, the lower compliance score of 67% for resolution timeliness was due to the lack of appropriate resources to process referral requests timely and Guiding Care upgrade issues.

- Medi-Cal Utilization Management: Urgent Prior Authorizations Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
September 2021	100%	80%	100%	100%	100%	50%

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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October 2021	100%	60%	100%	100%	100%	100%
November 2021	100%	50%	100%	100%	100%	86%

- Based on a focused review of ten (10) Medi-Cal urgent prior authorizations for November 2021, the lower compliance score of 50% for resolution timeliness was due to the lack of appropriate resources to process referral requests timely and Guiding Care upgrade issues.
- Based on a focused review of seven (7) Medi-Cal urgent prior authorizations for November 2021, the lower compliance score of 86% for member notice content was due to two (2) files exceeding the sixth (6^{th}) grade reading level.

3. Internal Monitoring: OneCare [a\]

- OneCare GARS: Standard Appeals Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
September 2021	100%	100%	100%	100%	100%	100%
October 2021	100%	100%	100%	50%	100%	100%
November 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

- Nothing to report for November data.

- OneCare GARS: Payment Reconsiderations (PREC) Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
September 2021	100%	100%	N/A	100%	N/A	100%
October 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2021	100%	100%	N/A	100%	N/A	100%

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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- No significant trends for November data.

- OneCare GARS: Standard Grievances Reporting of monitoring includes the most results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
September 2021	100%	100%	100%	83%	100%
October 2021	100%	100%	100%	92%	100%
November 2021	100%	100%	100%	92%	100%

- Based on a focused review of thirteen (13) OneCare standard grievances for November 2021, the lower compliance score of 92% for member notice content was due to the use of inaccurate templates for the resolution letter.

- OneCare Utilization Management: Standard Pre-Service Organization Determinations (SOD) Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
September 2021	N/A	N/A	N/A	N/A	N/A	N/A
October 2021	N/A	N/A	N/A	N/A	N/A	N/A
November 2021	N/A	N/A	N/A	N/A	N/A	N/A

- Nothing to report for November 2021.

4. Internal Monitoring: OneCare Connect [a\]

- OneCare Connect GARS: Standard Appeals Reporting of monitoring includes the most recent results available at the time of reporting.

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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Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
September 2021	100%	87.50%	100%	100%	100%	100%
October 2021	100%	100%	100%	100%	100%	100%
November 2021	100%	100%	100%	100%	100%	100%

➢ No trends to report for November data.

- OneCare Connect GARS: Expedited Appeals Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	Classification Score	Standard Appeals Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Clinical Decision Making	Member Notice Content	Resolution of Appeals within ≤ 30 Calendar Days of Receipt
September 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
October 2021	100%	N/A	100%	100%	100%	100%
November 2021	100%	N/A	100%	100%	100%	100%

➢ No trends to report for November data.

- OneCare Connect GARS: Standard Grievances Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	Classification Score	Standard Grievance Acknowledged within ≤ 5 Calendar Days of Receipt	Language Preference	Member Notice Content	Resolution of Grievance within ≤ 30 Calendar Days of Receipt
September 2021	100%	100%	100%	93%	100%
October 2021	100%	100%	100%	100%	100%
November 2021	100%	100%	100%	87%	100%

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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- Based on a focused review of fifteen (15) OneCare Connect standard grievances for November 2021, the lower compliance score of 87% for member notice content was due to two (2) files in which the statements in the resolution letter were not supported by documentation.

- OneCare Connect GARS: Expedited Grievances Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	Classification Score	Expedited Grievances Verbally Acknowledged within ≤ 24 Hours of Receipt	Language Preference	Member Notice Content	Expedited Grievances Resolved within ≤ 72 Hours of Receipt
September 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
October 2021	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
November 2021	100%	100%	100%	100%	100%

- No trends for November 2021.

- OneCare Connect Utilization Management: Standard Prior Authorizations Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content
September 2021	100%	100%	100%	100%	100%	90%
October 2021	100%	100%	100%	100%	100%	90%
November 2021	100%	100%	100%	100%	100%	100%

- No trends for November 2021.

- OneCare Connect Utilization Management: Expedited Prior Authorizations Reporting of monitoring includes the most recent results available at the time of reporting.

Month(s)	File Classification	Resolution Timeliness	Provider and Member Notification Timeliness	Clinical Decision Making Review	Written Response in Member's Preferred Language	Accuracy of Member Notice Content

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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September 2021	100%	100%	100%	100%	N/A	100%
October 2021	100%	100%	100%	100%	N/A	100%
November 2021	100%	89%	78%	100%	100%	100%

- Based on a focused review of nine (9) Medi-Cal urgent prior authorizations for November 2021, the lower compliance score of 89% for resolution timeliness was due to the lack of appropriate resources to process referral requests timely and Guiding Care upgrade issues.
- Based on a focused review of nine (9) Medi-Cal urgent prior authorizations for November 2021, the lower compliance score of 78% for provider and member notification timeliness was due to staff not following the process for verbally notifying provider if unable to send the notification timely.

5. 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 Requests	Letter Score for Urgent Requests	Timely Routine Requests	Timely Denials	CDM for Denials	Letter Score for Denials	Timely Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests	Timely Deferrals	CDM for Deferrals	Letter Score for Deferrals
October 2021	91%	89%	97%	88%	94%	90%	96%	85%	85%	98%	100%	93%	99%
November 2021	93%	92%	96%	92%	85%	93%	93%	76%	89%	97%	80%	70%	100%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

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 Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2021	87%	95%	94%	95%
November 2021	89%	92%	87%	96%
December 2021	80%	93%	81%	97%

- Overall scores for Medi-Cal claims decreased in the aggregate for the December 2021 file review month.
- Based on the focus review of the) select files, eight (8) health networks attributed to the compliance score for paid claims timeliness during the month of December 2021 leading to an aggregate of 80%.
- Based on the focus review of the select files, eight (8) health networks attributed to the compliance score for denied claims timeliness during the month of December 2021 leading to an aggregate of 81%.
- Based on the focus review of the select files, eight (8) health networks attributed to the compliance score for paid claims accuracy during the month of December 2021 leading to an aggregate of 93%.
- Based on the focus review of the select files, six (6) health networks attributed to the compliance score for denied claims accuracy during the month of December 2021 leading to an aggregate of 97%.
- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims 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.

6. Health Network Monitoring: OneCare [a\]

- OneCare Utilization Management (UM): 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
October 2021	92%	100%	96%	99%	97%	100%	100%	100%

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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November 2021	100%	99%	95%	100%	98%	100%	92%	100%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2021	95%	96%	99%	83%
November 2021	90%	88%	93%	56%
December 2021	100%	98%	100%	96%

- Overall scores for OneCare Claims increased in the aggregate for the December 2021 file review month.
- Based on the focus review of select files, one (1) health network attributed to the compliance score for paid claims accuracy during the month of December 2021 leading to an aggregate of 98%.
- Based on the focus review of the select files, three (3) health networks attributed to the compliance score for denied claims accuracy during the month of December 2021 leading to an aggregate of 96%.
- CalOptima's claims department issued requests for corrective action plans (CAPs) or Pre-CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims 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.

7. Health Network Monitoring: OneCare Connect [a\]

- OneCare Connect Utilization Management (UM): Prior Authorization Requests

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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Month	Timeliness for Urgent Requests	Clinical Decision Making (CDM) for Urgent Requests	Letter Score for Urgent Requests	Timeliness for Routine Requests	Letter Score for Routine Requests	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified Requests	CDM for Modified Requests	Letter Score for Modified Requests
October 2021	92%	100%	92%	93%	97%	97%	85%	99%	72%	83%	100%
November 2021	100%	92%	97%	98%	96%	86%	87%	98%	90%	85%	97%
December 2021	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

- CalOptima Monthly Utilization Management (UM) Monitoring of Files.
  - CalOptima has suspended the monitoring of monthly UM files for the months of December 2021 and January 2022.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
October 2021	79%	86%	94%	88%
November 2021	80%	96%	98%	81%
December 2021	87%	90%	96%	97%

- Overall scores for OneCare Connect Claims increased in the aggregate for the December 2021 file review month.
- Based on the focus review of select files, three (3) health network attributed to the compliance score for paid claims timeliness during the month of December 2021 leading to an aggregate of 87%.
- Based on the focus review of the select files, three (3) health networks attributed to the compliance score for paid claims accuracy during the month of December 2021 leading to an aggregate of 90%.
- Based on the focus review of select files, one (1) health network attributed to the compliance score for denied claims timeliness during the month of December 2021 leading to an aggregate of 96%.
- Based on the focus review of the select files, four (4) health networks attributed to the compliance score for denied claims accuracy during the month of December 2021 leading to an aggregate of 97%.
- CalOptima's claims management department issued requests for corrective action plans (CAPs) or Pre – CAP to all health networks with deficiencies identified during the review of claims processing for timeliness and accuracy. The claims 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

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monitoring, and policy revisions to ensure timely and accurate processing of claims within regulatory requirements.

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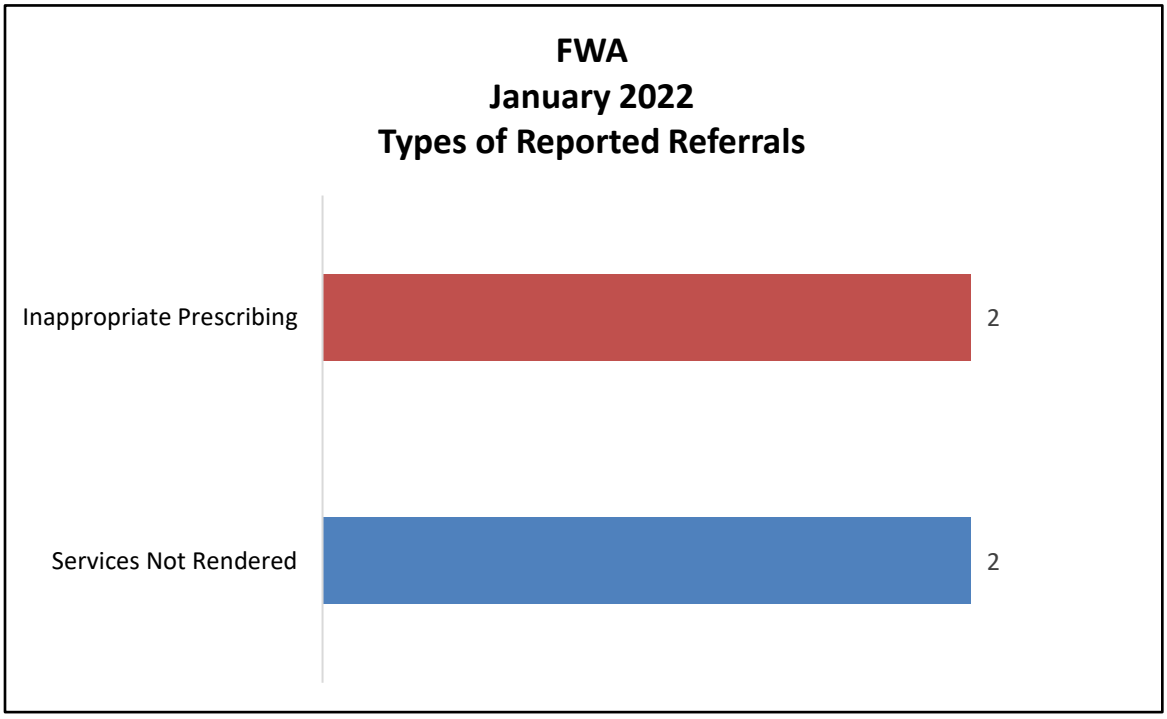
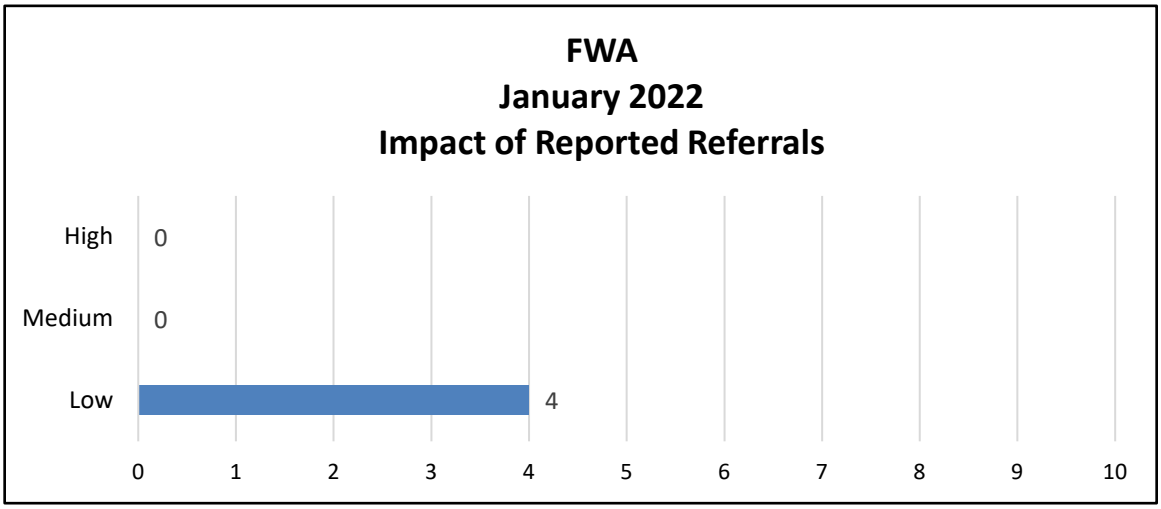
D. Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (January 2022)





Total Number of New Cases Referred to DHCS (State)	4
Total Number of New Cases Referred to I-MEDIC (CMS)*	4

*Effective January 1, 2022, CMS implemented a new portal to report suspicious and substantiated FWA. All potential FWA is now reported to CMS at the start of an investigation.

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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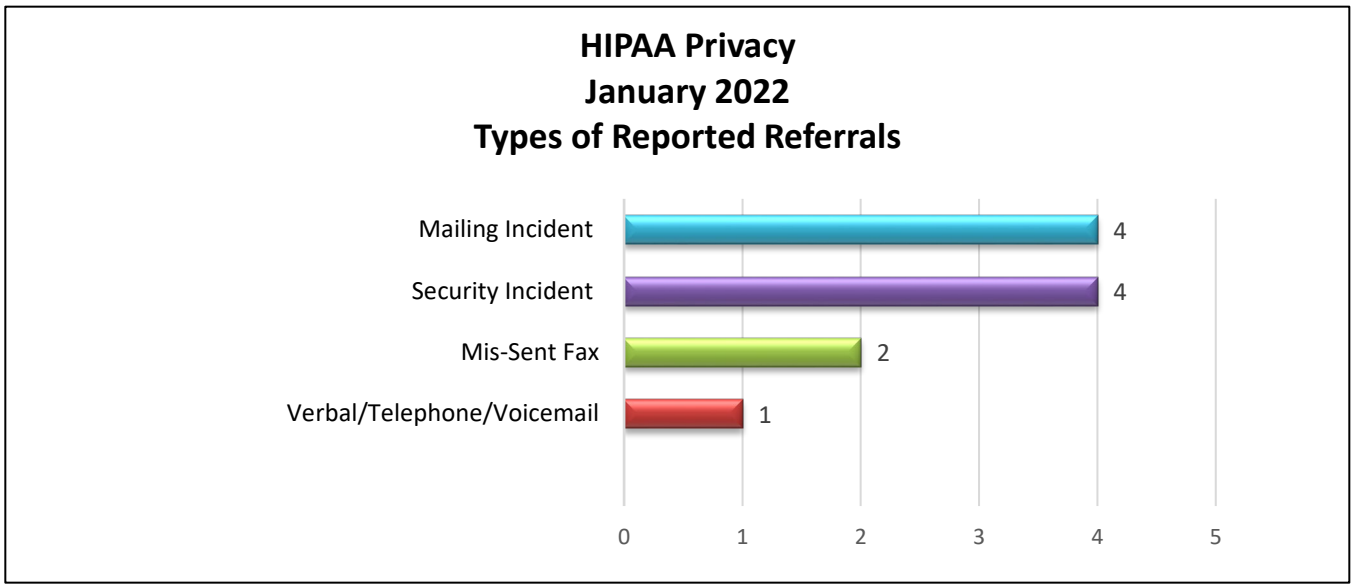
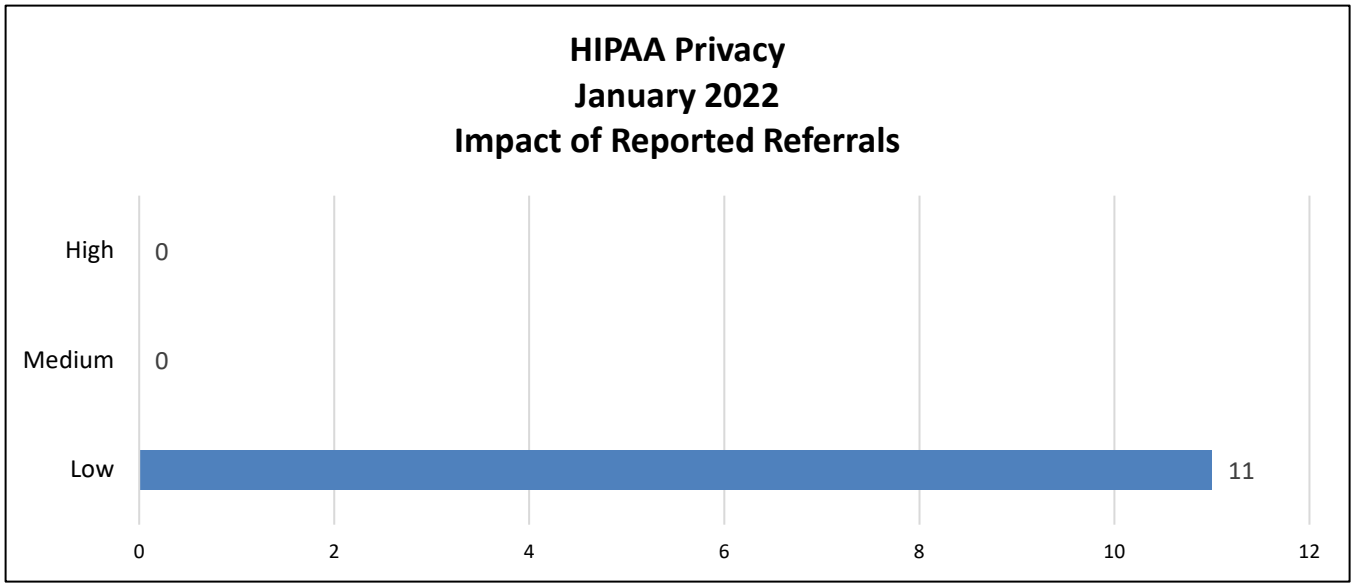
E. Privacy Update: (January 2022)





Total Number of Referrals Reported to DHCS (State)	11
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0

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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POTOMAC PARTNERS DC

STRATEGIC HEALTH CARE

M E M O R A N D U M

February 11, 2022

To: CalOptima

From: Potomac Partners DC & Strategic Health Care

Re: February Board of Directors Report

FISCAL YEAR 2022 APPROPRIATIONS

On Tuesday, February 8th, the House passed a Continuing Resolution (CR) to extend funding for the federal government until March 11th, 2022. The bill, H.R. 6617 – *Further Additional Extending Government Funding Act*, includes $350 million in supplemental funding to address water contamination in Hawaii, an extension of the $5,000 special assessment under the Justice for Victims of Trafficking Act, an extension of the temporary emergency order designating fentanyl as a Schedule I drug, and an extension of the current FMAP for certain territories. The Senate has yet to vote on the stopgap measure. Senate Majority Leader Chuck Schumer (D-NY) said that the Senate will take up the bill in time for the February 18th deadline.

A factsheet can be found here.
The 8-page bill with legislative text can be found here.

On February 9th, House and Senate Democratic Appropriators announced a "framework" agreement with Republicans that will pave the way for an omnibus spending package that will tentatively be signed into law by March 11th after the details have been negotiated. The details of the framework have not been released, but top Republican Senate Appropriator, Senator Shelby (R-AL), has said that there would not be a bill without parity between Defense and Non-Defense spending increases and the inclusion of the Hyde Amendment barring the use of federal funds to reimburse abortion procedures.

PROVIDER RELIEF FUND

There will reportedly be two more Provider Relief Fund payments as part of Phase 4: One in mid-February and the last in mid-March, for a total of about $5 billion. This will bring total Phase 4 funding to about $17 billion. HHS has confirmed that after the Phase 4 payments, the Provider Relief Fund will be without remaining funds. There is a congressional effort underway to add another $25 billion into the PRF by mid-March. About $1 billion remains in the Rural PRF, but it is uncertain how these funds will be spent. The HHS press release regarding the PRF payments is available here. The Phase 4 Terms and Conditions are available here.

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On February 9th, Senators Shaheen (D-NH) and Collins (R-ME) introduced a bill that would delay provider reporting requirements until after the end of the Public Health Emergency. Specifically, the bill would seek to:

- Extend current reporting and use-of-funds deadlines to the end of the pandemic.
- Ensure workplace safety improvements, such as security personnel, risk assessments and physical improvements, such as panic buttons and security cameras, are an allowable use of PRF dollars.
- Direct HRSA to distribute any funds remaining in the PRF by March 31, 2022.
- Create an application process for certain providers to receive funds returned in compliance with previous deadlines.

The *Provider Relief Fund Improvement Act* has endorsements from the American Hospital Association, the New Hampshire Hospital Association, and America's Essential Hospitals. Full text of the 9-page bill is available here.

PUBLIC HEALTH EMERGENCY DESIGNATION

On January 14th, HHS Secretary Becerra signed the renewal of the public health emergency (PHE), extending it for an additional 90 days through April 16, 2022. Under the law, PHEs may only be extended in 90-day increments. The Administration has indicated that they will continue to extend the PHE at least into the summer and that HHS will announce 60 days before they intend to end it. For the latest renewal, click here.

There appears to be a political effort underway to end the Public Health Emergency (PHE) much earlier than previously anticipated. Both the White House and Senate Minority Leader Mitch McConnell (R-KY) are talking about ending the PHE soon. Ending the PHE would have a significant impact on numerous programs that have been operating using pandemic waivers over the past two years. Everything from telehealth, hospital at home, and extra payments for persons receiving their health care coverage through Medicaid or on the exchanges would see severe disruptions. However, there is strong motivation for ending the PHE soon to significantly reduce government spending as the omicron variant subsides. HHS has promised to issue a 60-day notice before the end of the Public Health Emergency so we will be closely monitoring for any developments in the Administration or in Congress.

TELEHEALTH FUNDING

The Federal Communications Commission approved an additional 100 applications for funding commitments totaling $47.89 million for its Covid Telehealth Program. This is the FCC's sixth and final funding announcement of approved Round 2 applications. The FCC's Covid Telehealth Program supports the efforts of health care providers to continue serving their patients by providing reimbursement for telecommunications services, information services, and connected

devices necessary to enable telehealth during the Covid pandemic. For the press release, click here. For more on the program, click here.

COVID-19 TESTS

Starting January 15th, individuals with private health insurance coverage or covered by a group health plan who purchase an over-the-counter Covid diagnostic test authorized, cleared, or approved by the FDA are able to have those costs covered by their plan or insurance. Insurance companies and health plans are required to cover eight (8) free over-the-counter at-home tests per covered individual per month. There is no limit on the number of tests (including at-home tests) that are covered if ordered or administered by a health care provider following an individualized clinical assessment. For the press release on the requirement, click here. The White House announced that the Federal Government is purchasing one billion at-home, rapid Covid tests to give to Americans for free. Half of the available tests became available for order on January 19th and will be mailed directly to American households. For more information, click here.

VACCINE MANDATE

The CMS vaccine mandate that was upheld by the Supreme Court in January is set to go into effect in most states this month. The mandate applies to nearly all healthcare facilities that receive Medicare and Medicaid reimbursements. Facilities with less than 100% staff vaccination compliance rates may be cited, but they will be exempted from CMS enforcement actions if they meet the following criteria:

- If by the applicable Phase 1 deadline, the facility has more than 80% staff vaccination compliance rate (i.e., at least first dose) and a plan to achieve a 100% staff vaccination compliance rate within 60 days.
- If by the applicable Phase 2 deadline, the facility has more than 90% staff vaccination compliance rate (i.e., fully vaccinated) and a plan to achieve a 100% staff vaccination compliance rate within 30 days.

A FAQ from CMS on the regulations and key dates can be found here.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Jason D. Ikerd Associate Bridget E. McGowan Associate

February 18, 2022

LEGISLATIVE UPDATE

Edelstein Gilbert Robson & Smith LLC

The Legislature reconvened for the second year of the 2021-22 Legislative session on Monday January 3. In the first month of session, legislators focused much of their efforts on two-year bills that were still in their first house due to the House of Origin deadline on January 31.

As we previously reported, one of the bills left over from last year was AB 1400, the single-payer health care bill. While this bill received a lot of attention in the media, we predicted it would not become law. However, we were unsure where the bill would meet its demise. Turns out, AB 1400 died without a vote on the Assembly Floor. While the California Nurses Association (CNA) was lobbying hard to pass AB 1400 and the progressive wing of the Democratic Party threatened to withhold party endorsements from any Democrat who did not vote for the bill, there were not enough votes to pass the bill. The author chose not to bring the bill up for a vote rather than make his colleagues vote for a bill that would not pass. This decision infuriated the CNA, as they wanted to vote count so they could take retribution on those who voted against them. We do not believe this issue is going away. In fact, a new bill could be introduced this year.

Legislators have until today to introduce new legislation. After the House of Origin deadline passed, we have been seeing more bills introduced each day. As is typical for most years, more than 2,000 new bills will be introduced by the bill introduction deadline.

In the meantime, an issue has already emerged that threatens CalOptima and the COHS model. Rumors swirled for weeks that Kaiser Permanente (KP) was negotiating with the Newsom Administration to allow them to directly contract with the State for Medi-Cal services, rather than contract with local health plans like CalOptima. Public health plans repeatedly asked to meet with the Governor's staff to discuss this proposal, but we were turned away at every request. Once the deal was finalized, the Administration presented the details to local health plans.

Allowing KP to bypass CalOptima and other COHS to assume the care of Medi-Cal enrollees erodes the COHS model. CalOptima will no longer be the sole provider of Medi-Cal services in Orange County, which is a fundamental element of the COHS model.

The public health plans are united in their opposition to this secret no-bid contract and are coordinating a lobbying effort to derail it in the Legislature, which needs to approve the proposal. The Governor wants the proposal included in a budget trailer bill, where it

will receive little debate or resistance. The Administration released its expected trailer bill language yesterday. Public health plans are pushing to get the proposal placed in a policy bill, thereby allowing for more public debate.

Opposing the Governor and KP presents a daunting task that presents many interesting political challenges. We will continue to coordinate with CalOptima leadership as we proceed.

We have been scheduling meetings with the Orange County legislative delegation to introduce the CalOptima leadership team and to present the plan's policy goals. These meetings have been very well received and have presented an opportunity for us to share CalOptima's concerns regarding the KP deal.

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2021–22 Legislative Tracking Matrix

COVID-19 (CORONAVIRUS)

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4735 Axne (IA) **S. 2493 Bennet (CO)**	**Provider Relief Fund Deadline Extension Act:** Would delay the deadline by which providers must spend any funds received from the Provider Relief Fund — created in response to the COVID-19 pandemic — until the end of 2021 or the end of the COVID-19 public health emergency, whichever occurs later. Funds that are unspent by any deadline must be repaid to the U.S. Department of Health and Human Services (HHS). ***Potential CalOptima Impact:*** *Increased financial stability for CalOptima's contracted providers.*	**07/28/2021** Introduced; referred to committees	CalOptima: Watch

BEHAVIORAL HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1914 DeFazio (OR) **S. 764 Wyden (OR)**	**Crisis Assistance Helping Out On The Streets (CAHOOTS) Act:** Would allow State Medicaid programs to provide 24/7 community-based mobile crisis intervention services — under a State Plan Amendment or waiver — for those experiencing a mental health or substance use disorder crisis. Would provide states a 95% Federal Medical Assistance Percentage (FMAP) to cover such services for three years as well as a total of $25 million in planning grants. ***Potential CalOptima Impact:*** *Subject to further action by the California Department of Health Care Services (DHCS), increased behavioral health and substance use disorder services to CalOptima Medi-Cal members.*	**03/16/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support
AB 552 Quirk-Silva	**Integrated School-Based Behavioral Health Partnership Program:** Would establish the Integrated School-Based Behavioral Health Partnership Program to expand prevention and early intervention behavioral health services for students. This would allow a county mental health agency and local education agency to develop a formal partnership whereby county mental health professionals would deliver brief school-based services to any student who has, or is at risk of developing, a behavioral health condition or substance use disorder. ***Potential CalOptima Impact:*** *Increased coordination with the Orange County Health Care Agency and school districts to ensure non-duplication of other school-based behavioral health services and initiatives.*	**01/31/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch

COVERED BENEFITS

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 56 **Biggs (AZ)**	**Patient Access to Medical Foods Act:** Would expand the federal definition of medical foods to include food prescribed as a therapeutic option when traditional therapies have been exhausted or may cause adverse outcomes. Effective January 1, 2022, medical foods, as defined, would be covered by private health insurance providers and federal public health programs, including Medicare, TRICARE, Children's Health Insurance Program (CHIP) and Medicaid, as a mandatory benefit. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima's lines of business.*	**01/04/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 1118 **Dingell (MI)**	**Medicare Hearing Aid Coverage Act of 2021:** Effective January 1, 2022, would require Medicare Part B coverage of hearing aids and related examinations. ***Potential CalOptima Impact:*** *New covered benefit for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE).*	**02/18/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4187 **Schrier (WA)**	**Medicare Vision Act of 2021:** Effective January 1, 2024, would require Medicare Part B coverage of vision services, including eyeglasses, contact lenses, routine eye examinations and fittings. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and Program of All-Inclusive Care for the Elderly (PACE).*	**06/25/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4311 **Doggett (TX)** **S. 2618** **Casey (PA)**	**Medicare Dental, Vision, and Hearing Benefit Act of 2021:** Effective no sooner than January 1, 2022, would require Medicare Part B coverage of the following benefits: ■ Dental: Routine dental cleanings and examinations, basic and major dental services, emergency dental care, and dentures ■ Vision: Routine eye examinations, eyeglasses, contact lenses and low vision devices ■ Hearing: Routine hearing examinations, hearing aids and related examinations The Senate version would also increase the Medicaid FMAP for hearing, vision and dental services to 90%. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare, OneCare Connect and Program of All-Inclusive Care for the Elderly (PACE); higher federal funding rate for current Medi-Cal benefits.*	**07/01/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4650 **Kelly (IL)**	**Medicare Dental Coverage Act of 2021:** Effective January 1, 2025, would require Medicare Part B coverage of dental and oral health services, including routine dental cleanings and examinations, basic and major dental treatments, and dentures. ***Potential CalOptima Impact:*** *New covered benefits for CalOptima OneCare and Program of All-Inclusive Care for the Elderly (PACE).*	**07/22/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
SB 245 Gonzalez	**Abortion Services:** Would prohibit a health plan from imposing Medi-Cal cost-sharing on all abortion services, including any pre-abortion or follow-up care, no sooner than January 1, 2022. Likewise, a health plan may not require a prior authorization or impose an annual or lifetime limit on such coverage. ***Potential CalOptima Impact:*** *Modified Utilization Management (UM) procedures for a covered Medi-Cal benefit.*	**01/20/2022** Passed Assembly Appropriations Committee; referred to Assembly floor **06/01/2021** Passed Senate floor	CalOptima: Watch CAHP: Oppose
SB 912 Limón	**Biomarker Testing:** No later than July 1, 2023, would add biomarker testing, including whole genome sequencing, as a Medi-Cal covered benefit to diagnose, treat or monitor a disease. ***Potential CalOptima Impact:*** *New Medi-Cal covered benefit.*	**02/02/2022** Introduced	CalOptima: Watch

MEDI-CAL OPERATIONS AND ADMINISTRATION

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 1738 Dingell (MI) **S. 646 Brown (OH)**	**Stabilize Medicaid and CHIP Coverage Act of 2021:** Would provide 12 months of continuous eligibility and coverage for any Medicaid or CHIP beneficiary. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**03/10/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
H.R. 5610 Bera (CA) **S. 3001 Van Hollen (MD)**	**Easy Enrollment in Health Care Act:** To streamline and increase enrollment into public health insurance programs, would allow taxpayers to request their federal income tax returns include a determination of eligibility for Medicaid, CHIP or advance premium tax credits to purchase insurance through a health plan exchange. Taxpayers could also consent to be automatically enrolled into any such program or plan if they would be subject to a zero net premium. ***Potential CalOptima Impact:*** *Increased number of CalOptima Medi-Cal members.*	**10/19/2021** Introduced; referred to committees	CalOptima: Watch ACAP: Support
AB 1355 Levine	**Medi-Cal Independent Medical Review (IMR) System:** Would require DHCS to establish an IMR system for Medi-Cal managed care plans (MCPs), effective January 1, 2023. The bill would also provide every Medi-Cal beneficiary filing a grievance with access to an IMR. ***Potential CalOptima Impact:*** *Implementation of an additional Grievance and Appeals process for CalOptima Medi-Cal members.*	**01/27/2022** Passed Assembly floor; referred to Senate	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
AB 1400 **Kalra, Lee, Santiago**	**California Guaranteed Health Care for All:** Would create the California Guaranteed Health Care for All program (CalCare) to provide a comprehensive universal single-payer health care benefit for all California residents. Would require CalCare cover a wide range of medical benefits and other services and would incorporate the health care benefits and standards of CHIP, Medi-Cal, Medicare, the Knox-Keene Act, and ancillary health care or social services covered by regional centers for people with developmental disabilities. ***Potential CalOptima Impact:*** *Unknown but potentially significant impacts to the Medi-Cal delivery system and MCPs, including changes to administration, covered benefits, eligibility, enrollment, financing and organization.*	**01/31/2022** Died on Assembly floor	CalOptima: Watch CAHP: Oppose
SB 853 **Wiener**	**Medication Access Act:** Effective January 1, 2023, would require a health plan to cover a prescribed medication for the duration of utilization review and any appeals. Would prohibit a plan from seeking reimbursement from a beneficiary if a denial is sustained. ***Potential CalOptima Impact:*** *Modified UM and Grievance and Appeals requirements for prescribed drugs covered by CalOptima; increased CalOptima costs for drug coverage.*	**01/19/2022** Introduced	CalOptima: Watch
SB 858 **Wiener**	**Health Plan Civil Penalties:** Would increase the civil penalty amount that the California Department of Managed Health Care (DMHC) could levy on a health plan from no more than $2,500 per violation to no less than $25,000 per violation per impacted beneficiary per day. The penalty amount would be adjusted annually, beginning January 1, 2024. ***Potential CalOptima Impact:*** *Increased civil penalties for any violations of managed health care laws and regulations under the jurisdiction of DMHC.*	**01/19/2022** Introduced	CalOptima: Watch
SB 923 **Wiener**	**TGI Inclusive Care Act:** Would require health plan staff and contracted providers to complete cultural humility training to help provide inclusive health care services for individuals who identify as transgender, gender nonconforming or intersex (TGI). In addition, no later than July 31, 2023, would require a health plan to include in its provider directory any in-network providers who offer gender-affirming services. ***Potential CalOptima Impact:*** *Additional training requirement for CalOptima employees and contracted providers; additional requirement for provider directory publication.*	**02/03/2022** Introduced	CalOptima: Watch

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OLDER ADULT SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 4131 **Dingell (MI)** **S. 2210** **Casey (PA)**	**Better Jobs Better Care Act:** Would make permanent the enhanced 10% FMAP for Medicaid home- and community-based services (HCBS) enacted by the American Rescue Plan Act of 2021. Would also provide states with $100 million in planning grants to develop HCBS infrastructure and workforces. Additionally, would make permanent spousal impoverishment protections for those receiving HCBS. ***Potential CalOptima Impact:*** *Continuation of current federal funding rate for HCBS; expansion of HCBS opportunities.*	**06/24/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
H.R. 4941 **Blumenauer (OR)**	**PACE Part D Choice Act of 2021:** Would allow a Medicare-only PACE participant to opt out of drug coverage provided by the PACE program and instead enroll in a standalone Medicare Part D prescription drug plan that results in equal or lesser out-of-pocket costs. PACE programs would be required to educate their participants about this option. ***Potential CalOptima Impact:*** *Increased enrollment into CalOptima PACE by Medicare-only beneficiaries due to decreased out-of-pocket costs.*	**08/06/2021** Introduced; referred to committees	CalOptima: Watch NPA: Support
S. 1162 **Casey (PA)**	**PACE Plus Act:** Would increase the number of PACE programs nationally by making it easier for states to adopt PACE as a model of care and providing grants to organizations to start PACE centers or expand existing PACE centers. Would incentivize states to expand the number of seniors and people with disabilities eligible to receive PACE services beyond those deemed to require a nursing home level of care. Would provide states a 90% FMAP to cover the expanded eligibility. ***Potential CalOptima Impact:*** *Subject to further DHCS authorization, expanded eligibility for CalOptima PACE; additional federal funding to expand the service area of a current PACE center or to establish a new PACE center(s).*	**04/15/2021** Introduced; referred to committee	CalOptima: Watch CalPACE: Support NPA: Support

SOCIAL DETERMINANTS OF HEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 379 **Barragan (CA)** **S. 104** **Smith (MN)**	**Improving Social Determinants of Health Act of 2021:** Would require the Centers for Disease Control and Prevention (CDC) to establish a social determinants of health (SDOH) program to coordinate activities to improve health outcomes and reduce health inequities. CDC would be required to consider SDOH in all relevant grant awards and other activities as well as issue new grants of up to $50 million to health agencies, nonprofit organizations and/or institutions of higher education to address or study SDOH. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address SDOH.*	**01/21/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 943 McBath (GA) **S. 851 Blumenthal (CT)**	**Social Determinants for Moms Act:** Would require HHS to convene a task force to coordinate federal efforts on social determinants of maternal health as well as award grants to address SDOH, eliminate disparities in maternal health and expand access to free childcare during pregnancy-related appointments. Would also extend postpartum eligibility for the Special Supplemental Nutrition Program for Women, Infants, and Children from six months postpartum to two years postpartum. ***Potential CalOptima Impact:*** *Additional federal guidance or requirements as well as increased availability of federal grants to address social factors affecting maternal health.*	**02/08/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 2503 Bustos (IL)	**Social Determinants Accelerator Act of 2021:** Would establish the Social Determinants Accelerator Interagency Council to award state and local health agencies up to 25 competitive grants totaling no more than $25 million as well as provide technical assistance to improve coordination of medical and non-medical services to a targeted population of high-need Medicaid beneficiaries. ***Potential CalOptima Impact:*** *Increased availability of federal grants to address the SDOH of members with complex needs.*	**07/15/2021** Passed House Energy and Commerce Committee's Subcommittee on Health; referred to full Committee	CalOptima: Watch
H.R. 3894 Blunt Rochester (DE)	**Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2021:** Would require the Centers for Medicare & Medicaid Services (CMS) to update guidance at least once every three years to help states address SDOH in Medicaid and CHIP programs. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**12/08/2021** Passed House floor; referred to Senate Committee on Finance	CalOptima: Watch
H.R. 4026 Burgess (TX)	**Social Determinants of Health Data Analysis Act of 2021:** Would require the Comptroller General of the United States to submit a report to Congress outlining the actions taken by HHS to address SDOH. The report would include an analysis of interagency efforts, barriers and potential duplication of efforts as well as recommendations on how to foster private-public partnerships to address SDOH. ***Potential CalOptima Impact:*** *Increased opportunities for CalOptima to address SDOH.*	**11/30/2021** Passed House floor; referred to Senate Committee on Health, Education, Labor, and Pensions	CalOptima: Watch

TELEHEALTH

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 366 Thompson (CA)	**Protecting Access to Post-COVID-19 Telehealth Act of 2021:** Would allow HHS to waive or modify any telehealth service requirements in the Medicare program during a national disaster or public health emergency and for 90 days after one is terminated. Would also permit Medicare reimbursement for telehealth services provided by a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) as well as allow patients to receive telehealth services in the home without restrictions. ***Potential CalOptima Impact:*** *Continuation and expansion of certain telehealth flexibilities allowed during the COVID-19 pandemic for CalOptima OneCare, OneCare Connect and PACE.*	**01/19/2021** Introduced; referred to committees	CalOptima: Watch

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Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 2166 **Sewell (AL)**	**Ensuring Parity in MA and PACE for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for Medicare Advantage (MA) and PACE plans during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *For CalOptima OneCare, OneCare Connect and PACE, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**03/23/2021** Introduced; referred to committees	**08/05/2021** CalOptima: Support ACAP: Support NPA: Support
H.R. 2903 **Thompson (CA)** **S. 1512** **Schatz (HI)**	**Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021:** Would expand telehealth services for those receiving Medicare benefits and remove restrictions in the Medicare program that prevent physicians from using telehealth technology. Specifically, would: ■ Remove all geographic restrictions for telehealth services ■ Allow beneficiaries to receive telehealth in their own homes, in addition to other locations determined by HHS ■ Remove restrictions on the use of telehealth in emergency medical care ■ Allow FQHCs and RHCs to provide telehealth services ***Potential CalOptima Impact:*** *Continuation and expansion of telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**04/28/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 3447 **Smith (MO)**	**Permanency for Audio-Only Telehealth Act:** Would permanently extend the following current flexibilities, which have been temporarily authorized by CMS during the COVID-19 public health emergency: ■ Medicare providers may be reimbursed for providing certain services via audio-only telehealth, including evaluation and management, behavioral health and substance use disorder services, or any other service specified by HHS. ■ Medicare beneficiaries may receive telehealth services at any location, including their homes. ***Potential CalOptima Impact:*** *Permanent continuation of certain telehealth flexibilities for CalOptima OneCare, OneCare Connect and PACE.*	**05/20/2021** Introduced; referred to committees	CalOptima: Watch
H.R. 4058 **Matsui (CA)** **S. 2061** **Cassidy (LA)**	**Telemental Health Care Access Act of 2021:** Would remove the requirement that Medicare beneficiaries be seen in-person within six months of being treated for behavioral health services via telehealth. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, decreased in-person behavioral health encounters and increased telehealth behavioral health encounters.*	**06/22/2021** Introduced; referred to committees	CalOptima: Watch
S. 150 **Cortez Masto (NV)**	**Ensuring Parity in MA for Audio-Only Telehealth Act of 2021:** Would require CMS to include audio-only telehealth diagnoses in the determination of risk adjustment payments for MA plans during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *For CalOptima OneCare and OneCare Connect, members' risk scores and risk adjustment payments would accurately reflect diagnoses.*	**02/02/2021** Introduced; referred to committee	CalOptima: Watch ACAP: Support NPA: Support

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YOUTH SERVICES

Bill Number Author	Bill Summary	Bill Status	Position/Notes
H.R. 66 **Buchanan (FL)**	**Comprehensive Access to Robust Insurance Now Guaranteed (CARING) for Kids Act:** Would permanently extend authorization and funding of CHIP and associated programs, including the Medicaid and CHIP express lane eligibility option, which enables states to expedite eligibility determinations by referencing enrollment in other public programs. ***Potential CalOptima Impact:*** *Continuation of current federal funding and eligibility requirements for CalOptima Medi-Cal members eligible under CHIP.*	**01/04/2021** Introduced; referred to committee	CalOptima: Watch
H.R. 1390 **Wild (PA)** **S. 453** **Casey (PA)**	**Children's Health Insurance Program Pandemic Enhancement and Relief (CHIPPER) Act:** Would retroactively extend CHIP's temporary 11.5% FMAP increase, enacted by the HEALTHY KIDS Act (2018), from September 30, 2020, until September 30, 2022, to meet increased health care needs during the COVID-19 public health emergency. ***Potential CalOptima Impact:*** *Increased federal funds for CalOptima Medi-Cal members eligible under CHIP.*	**02/25/2021** Introduced; referred to committees	CalOptima: Watch

Two-Year Bills

The following bills did not meet the deadline to be passed by both houses of the State Legislature in 2021 but are still eligible for reconsideration in 2022:

- AB 4 (Arambula)
- AB 32 (Aguiar-Curry)
- AB 114 (Maienschein)
- AB 470 (Carrillo)
- AB 540 (Petrie-Norris)
- AB 563 (Berman)
- AB 586 (O'Donnell)
- AB 1132 (Wood)
- SB 17 (Pan)
- SB 56 (Pan)
- SB 250 (Pan)
- SB 256 (Pan)
- SB 293 (Limón)
- SB 316 (Eggman)
- SB 371 (Caballero)
- SB 523 (Leyva)
- SB 562 (Portantino)
- SB 773 (Roth)

Signed Bills

- H.R. 1868 (Yarmuth [KY])
- AB 128 (Ting)
- AB 133 (Committee on Budget)
- AB 161 (Ting)
- AB 164 (Ting)
- AB 361 (Rivas)
- AB 1082 (Waldron)
- SB 48 (Limón)
- SB 65 (Skinner)
- SB 129 (Skinner)
- SB 171 (Committee on Budget and Fiscal Review)
- SB 221 (Wiener)
- SB 306 (Pan)
- SB 510 (Pan)

Vetoed Bills

- AB 369 (Kamlager)
- AB 523 (Nazarian)
- SB 365 (Caballero)
- SB 682 (Rubio)

Information in this document is subject to change as bills proceed through the legislative process.

ACAP: Association for Community Affiliated Plans
CAHP: California Association of Health Plans
CalPACE: California PACE Association
LHPC: Local Health Plans of California
NPA: National PACE Association

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2022 Federal Legislative Dates

January 3	117th Congress, Second Session convenes
April 11–22	Spring recess
August 1–12	Summer recess for House
August 8–September 5	Summer recess for Senate
December 10	Second Session adjourns

2022 State Legislative Dates

January 3	Legislature reconvenes
January 14	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2021
January 21	Last day for any committee to hear and report to the floor any bill introduced in that house in 2021
January 31	Last day for each house to pass bills introduced in that house in 2021
February 18	Last day for legislation to be introduced
April 7–18	Spring recess
April 29	Last day for policy committees to hear and report to fiscal committees any fiscal bills introduced in that house in 2022
May 6	Last day for policy committees to hear and report to the floor any non-fiscal bills introduced in that house in 2022
May 20	Last day for fiscal committees to hear and report to the floor any bills introduced in that house in 2022
May 23–27	Floor session only
May 27	Last day for each house to pass bills introduced in that house in 2022
June 15	Budget bill must be passed by midnight
July 1	Last day for policy committees to hear and report bills in their second house to fiscal committees or the floor
July 1–August 1	Summer recess
August 12	Last day for fiscal committees to report bills in their second house to the floor
August 15–31	Floor session only
August 25	Last day to amend bills on the floor
August 31	Last day for each house to pass bills; final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2022 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
March 3, 2022

CalOptima Community Outreach Summary — February and March 2022

Background

CalOptima is committed to serving the community by sharing information with current and potential members and strengthening relationships with community partners. To do so, CalOptima attends community coalition/collaborative meetings and advisory groups, and supports our community partners' public activities.

CalOptima's participation in public activities promotes:

- Member interaction/enrollment in a CalOptima program
- Community awareness of CalOptima
- Partnerships that increase positive visibility and relationships with community organizations

CalOptima continues to participate in public activities, in most instances virtually, with limited in-person attendance. Participation includes providing CalOptima Medi-Cal educational materials and, if criteria are met, financial support and/or CalOptima-branded items.

Community Outreach Highlights

CalOptima hosted a virtual InfoSeries on CalAIM for providers and community stakeholders in January. The event provided an overview of CalAIM, updates on the launch, and information on Enhanced Care Management, Community Supports, and opportunities for referrals. There were 474 attendees representing member advocates, providers and community stakeholders, among others.

CalOptima and the Orange County Healthcare Agency are hosting seven additional COVID-19 vaccine events from February through April in the cities of Anaheim, Irvine, Garden Grove, and Santa Ana. More than 1,100 community members have been vaccinated through these events in 2022. February's vaccine event at Second Baptist Church was focused on serving CalOptima's African American members, given the low vaccination rate for that population. In addition, CalFresh information and enrollment will continue to be made available onsite.

Summary of Public Activities

As of January 31, CalOptima plans to participate in, organize, or convene 41 public activities in February and March. In February, there were 22 public activities including: 16 virtual community/collaborative meetings, 4 community events, 1 Cafecito and 1 Health Network Forum. In March, there will be 19 public activities: 15 virtual community/collaborative meetings, 3 community events and 1 Health Network Forum. CalOptima's participation in community meetings throughout Orange County can be found in the attachment.

Endorsements

CalOptima provided one endorsement since the last reporting period — a Letter of Support to Alzheimer's Orange County for the County of Orange Social Services Agency's OC Healthy Aging Assessment Services. Endorsement requests must meet the requirements of CalOptima Policy AA.1214: Guidelines for Endorsements by CalOptima for Letters of Support and Use of CalOptima Name and Logo. More information about policy requirements can be found at:
https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

For additional information or questions, contact CalOptima Community Relations Manager Tiffany Kaaiakamanu at 657-235-6872 or tkaaiakamanu@caloptima.org.

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List of community events hosted by community partners and CalOptima-hosted events and meetings in February and March 2022:

February 2022			
02/05–02/06 10 a.m.–5 p.m.	**Tet Festival hosted by the Union of Vietnamese Students Association of SoCal**† OC Fair and Event Center 88 Fair Dr. Costa Mesa	At least 16 staff members attended (in-person). Sponsorship fee: $10,000; included logo and link on website, resource table, banner display, color ad in event program book, speaking opportunity and 30-second video ad on main stage.	• Health/resource fair • Open to the public
02/05–02/06 10 a.m.–5 p.m.	**Tet Festival hosted by Viet America Society**† Mile Square Park 16801 Euclid St. Fountain Valley	At least 16 staff members attended (in-person). Sponsorship fee: $10,000; included a resource table, three banner displays, twenty-five radio impressions, fifteen television impressions, full-size ad, flyers distributed throughout the event and two 8x8 backdrops on the festival stage.	• Health/resource fair • Open to the public
02/7–02/9 9 a.m.– 4 p.m.	**26th Annual Conference hosted by Insure the Uninsured Project (ITUP)** Virtual	At least one staff member attended. Sponsorship fee: $2,500; included recognition as a general sponsor on the conference event page, ITUP website and conference marketing materials, such as social media and e-blast.	• Conference • Open to the public
2/17 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members attended.	• Forum • Open to health and human service providers
2/19 9 a.m.–1 p.m.	**Vaccine Event hosted by the County of Orange Health Care Agency and CalOptima*** Second Baptist Church 4300 Westminster Ave. Santa Ana	At least 10 staff members attended (in-person).	• Health/resource fair • Open to the public
2/23 9 a.m. –10:30 a.m.	**Cafecito Meeting** * Virtual	At least three staff members attended.	• Steering committee meeting • Open to collaborative members
March 2022			
3/12 9 a.m.–1 p.m.	**Vaccine Event hosted by the County of Orange Health Care Agency and CalOptima*** Golden West College Building 95 (MPR 100) 15751 Gothard St. Huntington Beach	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public
3/17 9 a.m. –11 a.m.	**Health Network Forum*** Virtual	At least 10 staff members to attend.	• Forum • Open to health and human service providers
3/19 9 a.m. – 1 p.m.	**Vaccine Event hosted by the County of Orange Health Care Agency and CalOptima***	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public

* CalOptima Hosted
† Exhibitor/Attendee

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	St. Anthony Claret Catholic Church 1450 E. La Palma Ave. Anaheim		
3/26 9 a.m.–1 p.m.	**Vaccine Event hosted by the County of Orange Health Care Agency and CalOptima*** County of Orange Social Services Agency Central Regional Office 2020 W. Walnut St. Santa Ana	At least 10 staff members to attend (in-person).	• Health/resource fair • Open to the public

These sponsorship request(s) and community event(s) met the requirements of CalOptima Policy AA.1223: Participation in Community Events Involving External Entities. More information about policy requirements can be found at: https://www.caloptima.org/en/About/CommunityRelations/CommunityOutreach.aspx.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Adopt Resolution Approving and Adopting Updated CalOptima Policy GA.8058: Salary Schedule; Authorize the Interim Chief Executive Officer to Implement Cost-of-Living Adjustments and Changes to Executive Level Job Titles, and Appropriation of Funds and Authorization of Unbudgeted Expenditures

Contacts

Michael Hunn, Interim Chief Executive Officer, (657) 900-1481
Brigette Hoey, Executive Director, Human Resources, (714) 246-8405

Recommended Actions

1. Adopt Resolution Approving Updated CalOptima Policy GA.8058: Salary Schedule and Attachment A – CalOptima Annual Base Salary Schedule (Attachment A);
2. Authorize the Interim Chief Executive Officer (CEO) to implement six percent (6%) salary increases as cost-of-living adjustments (COLAs) for all employees
3. Authorize the Interim CEO to implement changes to the chief and executive director positions with one (1) net increase to the total number of executive level positions
4. Appropriate funds and authorize unbudgeted expenditures in an amount up to $3.6 million from salary savings to fund COLAs and changes to executive level positions through June 30, 2022.

Background and Discussion

Salary Schedule and COLAs

Near CalOptima's inception, the Board of Directors delegated authority to the CEO to develop and implement employee policies and procedures, and to amend them as appropriate from time to time, subject to annual updates to the Board, with emphasis on changes. CalOptima's Bylaws require that the Board adopt by resolution, and from time to time amend, procedures, practices, and policies for, among other things, hiring employees and managing personnel. Additionally, pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

CalOptima Policy GA.8058 Salary Schedule and Attachment A are presented with the proposed changes as follows: 56 job titles removed, 19 job titles added, 16 job titles revised to better reflect actual job responsibilities, or to reduce the overall number of job titles, 7 pay grade changes reflective of the current market, and increases of ten percent (10%) to all pay grade maximums, and recalculation of pay grade midpoints. Pay grade minimums remain unchanged.

In 2021, a record-breaking number of employees resigned from their jobs. In fact, according to the Bureau of Labor Statistics, of the 68.9 million separations of employment, 47.4 million were employee resignations. Employees resigned for a variety of reasons, some of which included COVID-related concerns. Employers are offering remote work and sign-on bonuses, paying off student debt, reducing work hours, and paying higher wages, in efforts to retain and attract employees.
With respect to CalOptima's wages, the Board approved updates to CalOptima's Salary Schedule in

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March, August, and September of 2021. These updates were based on compensation data collected by a compensation consultant in 2018. Therefore, to keep up with the extremely competitive job market and mitigate the impact inflation has had on wages, staff recommends the Board authorize ten percent (10%) increases to the Salary Schedule pay grade maximums and recalculation of pay grade midpoints, and implementation of six percent (6%) salary increases as cost-of-living adjustments (COLAs) for all employees effective March 13, 2022.

The amount of the increases to the pay grade maximums and salary increases are recommended based on increases in the Consumer Price Index for all Urban Consumers (CPI-U) of 14.04% (Los Angeles, Long Beach, Anaheim area) and 17.20% (Riverside, San Bernardino area) from 2018 to the end of 2021. In 2021 alone, CPI-U increased approximately seven percent (7%) for our local area. The pay grade and salary increases are intended to mitigate the impact inflation has had on wages since 2018 and particularly in 2021.

Executive Level Positions
According to the Compensation Administration Guidelines, additional positions at the level of chief or executive director require Board approval. Currently, nineteen (19) positions have been Board authorized at the level of chief (8) and executive director (11). Staff proposes a variety of changes that result in one (1) net addition to the total number of chief or executive director positions.

Staff recommends the following changes to the executive director positions:

- Renaming all the Executive Director job titles to simply “Executive Director” to reduce the overall number of job titles on the Salary Schedule and to create greater flexibility to re-assign leadership oversight based on evolving business needs
- Adding two (2) executive director positions - one to oversee marketing & communications and another to provide much needed leadership and oversight to senior programs (Medicare and PACE)
- Re-purposing Executive Director of Program Implementation to provide much needed leadership and oversight to CalAIM and Medi-Cal
- Replacing Executive Director Compliance with Chief Compliance Officer and
- Replacing Executive Director Human Resources with Chief Human Resources Officer to reflect the criticality of these roles in ensuring organizational success, compliance, and the ability to execute the strategic plans of CalOptima.

Staff recommends the following changes to the chief positions:

- Adding one (1) Chief Health Equity Officer position per Medi-Cal managed care contract requirement effective January 1, 2024. Staff anticipates recruiting for this position in fiscal year 2022-23.
- Removing the Chief Counsel and Deputy Chief Counsel job titles from the Salary Schedule since legal services are no longer provided in-house.

The table below is provided as a reference of current and proposed chief and executive director job titles

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and depicts one (1) net gain in chief positions and no (0) net gains in executive director positions for a total of twenty (20) executive level positions. For purposes of this count, Chief of Staff was counted as an executive director position.

Current Title	**Proposed Title**
1) Chief Counsel	*Remove from Salary Schedule*
2) Chief Executive Officer	1) Chief Executive Officer
3) Chief Financial Officer	2) Chief Financial Officer
4) Chief Information Officer	3) Chief Information Officer
5) Chief Medical Officer	4) Chief Medical Officer
6) Chief Operating Officer	5) Chief Operating Officer
7) Chief of Staff	6) Chief of Staff
8) Deputy Chief Counsel	*Remove from Salary Schedule*
9) Deputy Chief Medical Officer	7) Deputy Chief Medical Officer
10) Executive Director Behavioral Health Integration	8) Executive Director
11) Executive Director Clinical Operations	9) Executive Director
12) Executive Director Compliance	10) Chief Compliance Officer
13) Executive Director Finance	11) Executive Director
14) Executive Director Human Resources	12) Chief Human Resources Officer
15) Executive Director Network Operations	13) Executive Director
16) Executive Director Operations	14) Executive Director
17) Executive Director Program Implementation	15) Executive Director[1]
18) Executive Director Public Affairs	16) Executive Director
19) Executive Director Quality & Population Health	17) Executive Director
N/A	18) Executive Director[2]
N/A	19) Executive Director[3]
N/A	20) Chief Health Equity Officer

[1]CalAIM and Medi-Cal; [2] Marketing & Communications; [3]Senior Programs (Medicare and PACE)

Policy No./Name	Summary of Changes	Reason for Change	Impact
GA.8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment A – Salary Schedule has been revised to reflect a ten percent (10%)	• Pursuant to CalPERS requirement, 2 CCR 570.5 • To keep up with the extremely competitive job market and mitigate the impact inflation has had on wages. • CalOptima periodically	• Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima must update the salary schedule to reflect current job titles and pay rates for each job position. • Implementing

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	increase to all pay grade maximums and recalculation of pay grade midpoints, 56 job titles removed, 19 job titles added, 16 job titles revised and 7 pay grades revised.	updates the salary schedule to reflect current job titles and pay grades for each classification. • The proposed implementation date of the Salary Schedule updates is March 13, 2022.	changes to the salary schedule with an implementation date of March 13, 2022 will coincide with the start of the next pay period for ease of administration.

Fiscal Impact

The recommended actions are unbudgeted. An appropriation up to $3.6 million from salary savings will fund these actions for the period of March 13, 2022, through June 30, 2022. Management will include updated salaries and benefits in the CalOptima Fiscal Year 2022-23 Operating Budget.

Concurrence

James Novello, General Outside Counsel

Attachments

1. Resolution No. 22-0303-02, Approve Updated Human Resources Policy
2. Revised CalOptima Policy
   a. GA.8058: Salary Schedule (redlined and clean copies) with revised Attachment A
   b. Summary of Changes to Salary Schedule
3. GA.8047 Compensation Program and Attachment A Compensation Administration Guidelines

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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RESOLUTION NO. 22-0303-02

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

APPROVE UPDATED CALOPTIMA POLICY GA 8058: SALARY SCHEDULE

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy:

a. GA.8058: Salary Schedule with Attachment to be Implemented March 13, 2022

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this March 3, 2022.

AYES:_____
NOES:_____
ABSENT:_____
ABSTAIN:_____

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Andrew Do, Chair, CalOptima Board of Directors

Attest:
/s/_____
Sharon Dwiers, Clerk of the Board

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	03/03/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20220303 BOD Review Only

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

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

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

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

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule ~~((~~Revised: ~~as of 09/02/2021~~03/03/2022)

V. REFERENCE(S)

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

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors

For 20220303 BOD Review Only

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

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

For 20220303 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative

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For 20220308 BOD Review Only

GLOSSARY

Not Applicable

For 20220303 BOD Review Only

Policy:	GA.8058
Title:	**Salary Schedule**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/*
Effective Date:	05/01/2014
Revised Date:	03/03/2022
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

For 20220303 BOD Review Only

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule meets the requirements above and is available at CalOptima's offices, immediately accessible for public review during normal business hours and posted on CalOptima's internal and external websites.

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

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

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

IV. ATTACHMENT(S)

A. CalOptima - Annual Base Salary Schedule (Revised: 03/03/2022)

V. REFERENCE(S)

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

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
10/01/2015	Regular Meeting of the CalOptima Board of Directors
12/03/2015	Regular Meeting of the CalOptima Board of Directors
03/03/2016	Regular Meeting of the CalOptima Board of Directors
06/02/2016	Regular Meeting of the CalOptima Board of Directors
08/04/2016	Regular Meeting of the CalOptima Board of Directors
09/01/2016	Regular Meeting of the CalOptima Board of Directors
10/06/2016	Regular Meeting of the CalOptima Board of Directors
11/03/2016	Regular Meeting of the CalOptima Board of Directors

For 20220303 BOD Review Only

Date	Meeting
12/01/2016	Regular Meeting of the CalOptima Board of Directors
03/02/2017	Regular Meeting of the CalOptima Board of Directors
05/04/2017	Regular Meeting of the CalOptima Board of Directors
06/01/2017	Regular Meeting of the CalOptima Board of Directors
08/03/2017	Regular Meeting of the CalOptima Board of Directors
09/07/2017	Regular Meeting of the CalOptima Board of Directors
11/02/2017	Regular Meeting of the CalOptima Board of Directors
02/01/2018	Regular Meeting of the CalOptima Board of Directors
09/06/2018	Regular Meeting of the CalOptima Board of Directors
10/04/2018	Regular Meeting of the CalOptima Board of Directors
02/07/2019	Regular Meeting of the CalOptima Board of Directors
08/01/2019	Regular Meeting of the CalOptima Board of Directors
09/03/2020	Regular Meeting of the CalOptima Board of Directors
03/04/2021	Regular Meeting of the CalOptima Board of Directors
08/05/2021	Regular Meeting of the CalOptima Board of Directors
09/02/2021	Regular Meeting of the CalOptima Board of Directors
03/03/2022	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

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

For 20220303 BOD Review Only

Action	Date	Policy	Policy Title	Program(s)
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08/03/2017	GA.8058	Salary Schedule	Administrative
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative
Revised	09/06/2018	GA.8058	Salary Schedule	Administrative
Revised	10/04/2018	GA.8058	Salary Schedule	Administrative
Revised	02/07/2019	GA.8058	Salary Schedule	Administrative
Revised	08/01/2019	GA.8058	Salary Schedule	Administrative
Revised	09/03/2020	GA.8058	Salary Schedule	Administrative
Revised	03/04/2021	GA.8058	Salary Schedule	Administrative
Revised	08/05/2021	GA.8058	Salary Schedule	Administrative
Revised	09/02/2021	GA.8058	Salary Schedule	Administrative
Revised	03/03/2022	GA.8058	Salary Schedule	Administrative

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For 20220308 BOD Review Only

GLOSSARY

Not Applicable

For 20220303 BOD Review Only

CalOptima - Annual Base Salary Schedule - Revised: ~~September 02, 2021~~ March 03, 2022
To be Implemented: ~~September 12, 2021~~ March 13, 2022
~~Effective as of May 01, 2014~~

Job Title	Pay Grade	Job Code	Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
Accountant	H	39	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Accountant Int	I	634	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Accountant Sr	K	68	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Accounting Clerk	D	334	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Increase pay grade maximum by 10% and calculate midpoint.
Accounting Clerk Sr	E	680	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Activity Coordinator (PACE)	E	681	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Actuarial Analyst	~~I~~ K	558	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
Actuarial Analyst Sr	L	559	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Actuary	O	357	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Actuary Principal	Q	TBD	$130,000		$166,200		$202,400	Add Title
Actuary Sr	P	TBD	$117,000		$149,250		$181,500	Add Title
Administrative Assistant	D	19	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Increase pay grade maximum by 10% and calculate midpoint.
Analyst	H	562	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Analyst Int	I	563	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Analyst Sr	J	564	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Applications Analyst	I	232	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Applications Analyst Int	J	233	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Applications Analyst Sr	L	298	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
~~Associate Director~~	~~P~~	~~682~~	~~$117,000~~	~~$141,000~~		~~$165,000~~		Remove Title
~~Associate Director Customer Service~~	~~P~~	~~593~~	~~$117,000~~	~~$141,000~~		~~$165,000~~		Remove Title
~~Associate Director Grievance & Appeals~~	~~P~~	~~TBD~~	~~$117,000~~	~~$141,000~~		~~$165,000~~		Remove Title
Associate Director I	P	TBD	$117,000		$149,250		$181,500	Add Title
Associate Director II	Q	TBD	$130,000		$166,200		$202,400	Add Title
Associate Director III	R	TBD	$144,000		$184,200		$224,400	Add Title
~~Associate Director Information Services~~	~~Q~~	~~557~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title
Associate Director IV	S	TBD	$154,000		$204,600		$255,200	Add Title

CalOptima - Annual Base Salary Schedule - Revised: ~~September 02, 2021~~ March 03, 2022
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Job Title	Pay Grade	Job Code	Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
Auditor	I	565	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Auditor Sr	J	566	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Behavioral Health Manager	M	383	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Biostatistics Manager	M	418	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Board Services Specialist	E	435	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Business Analyst	J	40	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Business Analyst Sr	L	611	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Business Systems Analyst Sr	K	69	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Buyer	G	29	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Buyer Int	H	49	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Buyer Sr	I	67	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Care Manager	K	657	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Care Transition Intervention Coach (RN)	L	417	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Certified Coder	H	399	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Certified Coding Specialist	H	639	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Certified Coding Specialist Sr	J	640	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Change Control Administrator	I	499	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Change Control Administrator Int	J	500	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
** Chief Compliance Officer	W	TBD	$313,000		$414,450		$515,900	Add title
** ~~Chief Counsel~~	~~X~~	~~132~~	~~$368,000~~	~~$460,000~~		~~$552,000~~		Remove Title
** Chief Executive Officer	Z	138	$560,000	~~$625,000~~	$700,750	~~$765,000~~	$841,500	Increase pay grade maximum by 10% and calculate midpoint.

CalOptima - Annual Base Salary Schedule - Revised: ~~September 02, 2021~~ March 03, 2022
To be Implemented: ~~September 12, 2021~~ March 13, 2022
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Job Title	Pay Grade	Job Code	Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
** Chief Financial Officer	X	134	$368,000	~~$460,000~~	$487,600	~~$552,000~~	$607,200	Increase pay grade maximum by 10% and calculate midpoint.
** Chief Health Equity Officer	W	TBD	$313,000		$414,450		$515,900	Add title
** Chief Human Resources Officer	W	TBD	$313,000		$414,450		$515,900	Add title
** Chief Information Officer	W	131	$313,000	~~$391,000~~	$414,450	~~$469,000~~	$515,900	Increase pay grade maximum by 10% and calculate midpoint.
** Chief Medical Officer	X	137	$368,000	~~$460,000~~	$487,600	~~$552,000~~	$607,200	Increase pay grade maximum by 10% and calculate midpoint.
** Chief of Staff	U	TBD	$226,000	~~$282,000~~	$298,900	~~$338,000~~	$371,800	Increase pay grade maximum by 10% and calculate midpoint.
** Chief Operating Officer	Y	136	$433,000	~~$540,909~~	$573,450	~~$649,000~~	$713,900	Increase pay grade maximum by 10% and calculate midpoint.
Claims - Lead	G	574	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Claims Examiner	C	9	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Claims Examiner - Lead	F	236	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Claims Examiner Sr	E	20	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Claims QA Analyst	~~E~~ F	28	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
Claims QA Analyst Sr	~~F~~ G	540	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
Claims Recovery Specialist	F	283	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Claims Resolution Specialist	F	262	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Clerk of the Board	O	59	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Clinical Auditor	L	567	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Clinical Auditor Sr	M	568	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Clinical Documentation Specialist (RN)	M	641	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Clinical Pharmacist	P	297	$117,000	~~$141,000~~	$149,250	~~$165,000~~	$181,500	Increase pay grade maximum by 10% and calculate midpoint.
Clinical Systems Administrator	K	607	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.

CalOptima - Annual Base Salary Schedule - Revised: ~~September 02, 2021~~ March 03, 2022
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Job Title	Pay Grade	Job Code	Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
Clinician (Behavioral Health)	K	513	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Communications Specialist	G	188	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Communications Specialist - Lead	J	TBD	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Communications Specialist Sr	H	TBD	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Community Partner	G	575	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Community Partner Sr	H	612	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Community Relations Specialist	G	288	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Community Relations Specialist Sr	I	646	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Compliance Claims Auditor	G	222	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Compliance Claims Auditor Sr	H	279	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Contract Administrator	K	385	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Contracts Manager	M	207	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Contracts Manager Sr	N	683	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Contracts Specialist	I	257	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Contracts Specialist Int	J	469	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Contracts Specialist Sr	K	331	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
* Controller	T	464	$182,000	~~$227,000~~	$240,600	~~$272,000~~	$299,200	Increase pay grade maximum by 10% and calculate midpoint.
Credentialing Coordinator	E	41	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Credentialing Coordinator - Lead	F	510	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Customer Service Coordinator	E	182	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.

CalOptima - Annual Base Salary Schedule - Revised: ~~September 02, 2021~~ March 03, 2022
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	Job Title	Pay Grade	Job Code	Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
	Customer Service Rep	C	5	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
	Customer Service Rep - Lead	E	482	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
	Customer Service Rep Sr	D	481	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Increase pay grade maximum by 10% and calculate midpoint.
	Data Analyst	J	337	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
	Data Analyst Int	K	341	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
	Data Analyst Sr	L	342	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
	Data and Reporting Analyst - Lead	M	654	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Data Entry Tech	A	3	$36,000	~~$41,000~~	$43,300	~~$46,000~~	$50,600	Increase pay grade maximum by 10% and calculate midpoint.
	Data Warehouse Architect	N	363	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
	Data Warehouse Programmer/Analyst	N	364	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
	Data Warehouse Reporting Analyst	M	412	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
	Database Administrator	L	90	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
	Database Administrator Sr	N	179	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
**	~~Deputy Chief Counsel~~	~~W~~	~~160~~	~~$313,000~~	~~$391,000~~		~~$469,000~~		Remove Title
**	Deputy Chief Medical Officer	W	561	$313,000	~~$391,000~~	$414,450	~~$469,000~~	$515,900	Increase pay grade maximum by 10% and calculate midpoint.
	Deputy Clerk of the Board	K	684	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
*	~~Director Audit & Oversight~~	~~R~~	~~546~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Behavioral Health Services~~	~~S~~	~~392~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Budget and Procurement~~	~~S~~	~~527~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Case Management~~	~~S~~	~~318~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Claims Administration~~	~~R~~	~~112~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Clinical Pharmacy~~	~~T~~	~~129~~	~~$182,000~~	~~$227,000~~		~~$272,000~~		Remove Title
*	~~Director Coding Initiatives~~	~~S~~	~~375~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Communications~~	~~R~~	~~361~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Community Relations~~	~~R~~	~~TBD~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Contracting~~	~~R~~	~~184~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Customer Service~~	~~R~~	~~118~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Data Management Services~~	~~Q~~	~~TBD~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title

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*	~~Director Enterprise Analytics~~	~~R~~	~~520~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Facilities~~	~~Q~~	~~428~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title
*	~~Director Financial Analysis~~	~~T~~	~~374~~	~~$182,000~~	~~$227,000~~		~~$272,000~~		Remove Title
*	~~Director Financial Compliance~~	~~R~~	~~460~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Fraud Waste & Abuse and Privacy~~	~~R~~	~~581~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Government Affairs~~	~~R~~	~~277~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Grievance & Appeals~~	~~R~~	~~528~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Human Resources~~	~~S~~	~~322~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	Director I	Q	TBD	$130,000		$166,200		$202,400	Add Title
*	Director II	R	TBD	$144,000		$184,200		$224,400	Add Title
*	Director III	S	TBD	$154,000		$204,600		$255,200	Add Title
*	~~Director Information Services~~	~~T~~	~~547~~	~~$182,000~~	~~$227,000~~		~~$272,000~~		Remove Title
*	Director IV	T	TBD	$182,000		$240,600		$299,200	Add Title
*	~~Director Long Term Support Services~~	~~S~~	~~128~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Network Management~~	~~R~~	~~125~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director PACE Program~~	~~S~~	~~449~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Population Health Management~~	~~R~~	~~675~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Process Excellence~~	~~R~~	~~447~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Program Implementation~~	~~R~~	~~489~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Purchasing~~	~~Q~~	~~TBD~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title
*	~~Director Quality Analytics~~	~~R~~	~~591~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Quality Improvement~~	~~R~~	~~172~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Regulatory Affairs and Compliance~~	~~R~~	~~625~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Strategic Development~~	~~R~~	~~121~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
*	~~Director Utilization Management~~	~~S~~	~~265~~	~~$154,000~~	~~$193,000~~		~~$232,000~~		Remove Title
*	~~Director Vendor Management~~	~~Q~~	~~685~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title
	Enrollment Coordinator (PACE)	F	441	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
	Enterprise Analytics Manager	O	582	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
	Executive Administrative Services Manager	J	661	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
	Executive Assistant	G	339	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
	Executive Assistant to CEO	I	261	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
**	Executive Director	U	TBD	$226,000		$298,900		$371,800	Add Title
**	~~Executive Director Behavioral Health Integration~~	~~U~~	~~614~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Clinical Operations~~	~~U~~	~~501~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Compliance~~	~~U~~	~~493~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Finance~~	~~U~~	~~TBD~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Human Resources~~	~~U~~	~~494~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Network Operations~~	~~U~~	~~632~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Operations~~	~~U~~	~~276~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Program Implementation~~	~~U~~	~~490~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Public Affairs~~	~~U~~	~~290~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
**	~~Executive Director Quality & Population Health Management~~	~~U~~	~~676~~	~~$226,000~~	~~$282,000~~		~~$338,000~~		Remove Title
	Facilities & Support Services Coord - Lead	G	631	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
	Facilities & Support Services Coordinator	E	10	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.

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Facilities & Support Services Coordinator Sr	F	511	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Facilities Coordinator	E	438	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Financial Analyst	J	51	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Financial Analyst Sr	L	84	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Financial Reporting Analyst	I	475	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
~~Graphic Designer~~ Designer	K	387	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~Graphic Designer Sr~~ Designer Sr	L	TBD	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
Grievance & Appeals Nurse Specialist	M	226	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Grievance Resolution Specialist	F	42	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Grievance Resolution Specialist - Lead	I	590	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Grievance Resolution Specialist Sr	H	589	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Health Coach	K	556	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Health Educator	H	47	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Health Educator Sr	I	355	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Health Network Liaison Specialist (RN)	L	524	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Health Network Oversight Specialist	K	323	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
HEDIS Case Manager	M	443	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Help Desk Technician	E	571	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Help Desk Technician Sr	F	573	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.

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~~HR Assistant~~ Human Resources Assistant	D	181	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~HR Business Partner~~ Human Resources Business Partner	M	584	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~HR Coordinator~~ Human Resources Coordinator	F	316	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~HR Representative~~ Human Resources Representative	J	278	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~HR Representative Sr~~ Human Resources Representative Sr	L	350	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~HR Specialist~~ Human Resources Specialist	G	505	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~HR Specialist Sr~~ Human Resources Specialist Sr	H	608	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
Infrastructure Systems Administrator	F	541	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Infrastructure Systems Administrator Int	G	542	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Inpatient Quality Coding Auditor	I	642	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Intern	A	237	$36,000	~~$41,000~~	$43,300	~~$46,000~~	$50,600	Increase pay grade maximum by 10% and calculate midpoint.
Investigator Sr	I	553	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
~~IS Coordinator~~ Information Technology Services Coordinator	E	365	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~IS Project Manager~~ Information Technology Services Project Manager	N	424	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~IS Project Manager Sr~~ Information Technology Services Project Manager Sr	O	509	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~IS Project Specialist~~ Information Technology Services Project Specialist	K	549	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
~~IS Project Specialist Sr~~ Information Technology Services Project Specialist Sr	L	550	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Change Title; Increase pay grade maximum by 10% and calculate midpoint.

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Kitchen Assistant	A	585	$36,000	~~$41,000~~	$43,300	~~$46,000~~	$50,600	Increase pay grade maximum by 10% and calculate midpoint.
Licensed Clinical Social Worker	J	598	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Litigation Support Specialist	K	588	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
LVN (PACE)	K	533	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
LVN Specialist	K	686	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Mailroom Clerk	A	1	$36,000	~~$41,000~~	$43,300	~~$46,000~~	$50,600	Increase pay grade maximum by 10% and calculate midpoint.
Manager Accounting	O	98	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Actuary	~~Q~~ R	453	$144,000	~~$174,000~~	$184,200	~~$204,000~~	$224,400	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
Manager Audit & Oversight	O	539	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Behavioral Health	O	633	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Business Integration	O	544	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Case Management	P	270	$117,000	~~$141,000~~	$149,250	~~$165,000~~	$181,500	Increase pay grade maximum by 10% and calculate midpoint.
Manager Claims	O	92	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Clinic Operations	N	551	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Clinical Pharmacist	R	296	$144,000	~~$174,000~~	$184,200	~~$204,000~~	$224,400	Increase pay grade maximum by 10% and calculate midpoint.
Manager Coding Quality	N	382	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Communications	N	398	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Community Relations	N	384	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Contracting	O	329	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Creative Branding	M	430	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.

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Manager Cultural & Linguistic	M	349	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Customer Service	M	94	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Electronic Business	N	422	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Encounters	~~M~~ N	516	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
Manager Environmental Health & Safety	N	495	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Finance	O	148	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Financial Analysis	P	356	$117,000	~~$141,000~~	$149,250	~~$165,000~~	$181,500	Increase pay grade maximum by 10% and calculate midpoint.
Manager Government Affairs	N	437	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Grievance & Appeals	O	426	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Human Resources	O	526	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
~~Manager Information Services~~ Manager Information Technology Services	P	560	$117,000	~~$141,000~~	$149,250	~~$165,000~~	$181,500	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
Manager Long Term Support Services	O	200	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Marketing & Enrollment (PACE)	N	414	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Marketing & Outreach	M	687	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Member Liaison Program	M	354	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Member Outreach & Education	M	616	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager MSSP	O	393	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager OneCare Clinical	P	359	$117,000	~~$141,000~~	$149,250	~~$165,000~~	$181,500	Increase pay grade maximum by 10% and calculate midpoint.
Manager OneCare Customer Service	M	429	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Outreach & Enrollment	M	477	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.

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Manager PACE Center	N	432	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Population Health Management	N	674	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Process Excellence	O	622	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Program Implementation	N	488	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Provider Data Management Services	M	653	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Provider Network	O	191	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Provider Relations	M	171	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Purchasing	O	275	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager QI Initiatives	M	433	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Manager Quality Analytics	N	617	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Quality Improvement	N	104	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Manager Regulatory Affairs and Compliance	O	626	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Reporting & Financial Compliance	O	572	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Strategic Development	O	603	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Manager Utilization Management	P	250	$117,000	~~$141,000~~	$149,250	~~$165,000~~	$181,500	Increase pay grade maximum by 10% and calculate midpoint.
Marketing and Outreach Specialist	F	496	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Medical Assistant	C	535	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Medical Authorization Asst	C	11	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Medical Case Manager	L	72	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Medical Case Manager (LVN)	K	444	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.

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Job Title	Pay Grade	Job Code	Min	Mid	Proposed Mid	Max	Proposed Max	For Approval
* Medical Director	V	306	$266,000	~~$332,000~~	$351,900	~~$398,000~~	$437,800	Increase pay grade maximum by 10% and calculate midpoint.
Medical Records & Health Plan Assistant	B	548	$38,000	~~$44,000~~	$46,500	~~$50,000~~	$55,000	Increase pay grade maximum by 10% and calculate midpoint.
Medical Records Clerk	B	523	$38,000	~~$44,000~~	$46,500	~~$50,000~~	$55,000	Increase pay grade maximum by 10% and calculate midpoint.
Medical Services Case Manager	G	54	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Member Liaison Specialist	~~C~~ D	353	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
MMS Program Coordinator	G	360	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Nurse Practitioner (PACE)	O	635	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Occupational Therapist	L	531	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Occupational Therapist Assistant	H	623	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Office Clerk	A	335	$36,000	~~$41,000~~	$43,300	~~$46,000~~	$50,600	Increase pay grade maximum by 10% and calculate midpoint.
OneCare Operations Manager	N	461	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
OneCare Partner - Sales	F	230	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
OneCare Partner - Sales (Lead)	G	537	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
OneCare Partner - Service	C	231	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
OneCare Partner (Inside Sales)	E	371	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Outreach Specialist	C	218	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Paralegal/Legal Secretary	I	376	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Payroll Specialist	E	554	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Payroll Specialist Sr	G	688	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Performance Analyst	I	538	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.

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Personal Care Attendant	A	485	$36,000	~~$41,000~~	$43,300	~~$46,000~~	$50,600	Increase pay grade maximum by 10% and calculate midpoint.
Personal Care Attendant - Lead	B	498	$38,000	~~$44,000~~	$46,500	~~$50,000~~	$55,000	Increase pay grade maximum by 10% and calculate midpoint.
Personal Care Coordinator	C	525	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Personal Care Coordinator Sr	D	689	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Increase pay grade maximum by 10% and calculate midpoint.
Pharmacy Resident	G	379	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Pharmacy Services Specialist	C	23	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Pharmacy Services Specialist Int	D	35	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Increase pay grade maximum by 10% and calculate midpoint.
Pharmacy Services Specialist Sr	E	507	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Physical Therapist	L	530	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Physical Therapist Assistant	H	624	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Policy Advisor Sr	M	580	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Privacy Manager	N	536	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Privacy Officer	O	648	$105,000	~~$127,000~~	$134,450	~~$149,000~~	$163,900	Increase pay grade maximum by 10% and calculate midpoint.
Process Excellence Manager	N	529	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Program Assistant	C	24	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Program Coordinator	C	284	$41,000	~~$47,000~~	$49,650	~~$53,000~~	$58,300	Increase pay grade maximum by 10% and calculate midpoint.
Program Development Analyst Sr	K	492	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Program Manager	L	421	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Program Manager Sr	M	594	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Program Specialist	E	36	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.

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Program Specialist Int	G	61	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Program Specialist Sr	I	508	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Program/Policy Analyst	I	56	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Program/Policy Analyst Sr	K	85	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Programmer	K	43	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Programmer Int	M	74	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Programmer Sr	N	80	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Project Manager	L	81	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Project Manager - Lead	M	467	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Project Manager Sr	N	105	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Project Specialist	E	291	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Project Specialist Sr	I	503	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Projects Analyst	G	254	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Provider Data Management Services Coordinator	D	12	$44,000	~~$51,000~~	$53,900	~~$58,000~~	$63,800	Increase pay grade maximum by 10% and calculate midpoint.
Provider Data Management Services Coordinator Sr	F	586	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Provider Enrollment Manager	G	190	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Provider Network Rep Sr	I	391	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Provider Network Specialist	H	44	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Provider Network Specialist Sr	J	595	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Provider Office Education Manager	I	300	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.

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Provider Relations Rep	G	205	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Provider Relations Rep Sr	I	285	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Publications Coordinator	G	293	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
QA Analyst	I	486	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
QA Analyst Sr	L	380	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
QI Nurse Specialist	M	82	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
QI Nurse Specialist (LVN)	L	445	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Receptionist	B	140	$38,000	~~$44,000~~	$46,500	~~$50,000~~	$55,000	Increase pay grade maximum by 10% and calculate midpoint.
Records Manager	Q	TBD	$130,000	~~$157,000~~	$166,200	~~$184,000~~	$202,400	Increase pay grade maximum by 10% and calculate midpoint.
Recreational Therapist	H	487	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Registered Dietitian	I	57	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Regulatory Affairs and Compliance - Lead	L	630	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Regulatory Affairs and Compliance Analyst	I	628	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
RN (PACE)	M	480	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Security Analyst Int	M	534	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Security Analyst Sr	N	474	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Security Officer	B	311	$38,000	~~$44,000~~	$46,500	~~$50,000~~	$55,000	Increase pay grade maximum by 10% and calculate midpoint.
SharePoint Developer/Administrator Sr	N	397	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
Social Worker	J	463	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.

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	Social Worker Sr	K	690	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
*	~~Special Counsel~~	~~T~~	~~317~~	~~$182,000~~	~~$227,000~~		~~$272,000~~		Remove Title
*	Sr Director	T	TBD	$182,000		$240,600		$299,200	Add Title
	~~Sr Manager Financial Analysis~~	~~Q~~	~~660~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title
	~~Sr Manager Human Resources~~	~~P~~	~~649~~	~~$117,000~~	~~$141,000~~		~~$165,000~~		Remove Title
	Sr Manager I	P	TBD	$117,000		$149,250		$181,500	Add Title
	Sr Manager II	Q	TBD	$130,000		$166,200		$202,400	Add Title
	Sr Manager III	R	TBD	$144,000		$184,200		$224,400	Add Title
	~~Sr Manager Information Services~~	~~Q~~	~~650~~	~~$130,000~~	~~$157,000~~		~~$184,000~~		Remove Title
	Sr Manager IV	S	TBD	$154,000		$204,600		$255,200	Add Title
	~~Staff Attorney~~	~~P~~	~~195~~	~~$117,000~~	~~$141,000~~		~~$165,000~~		Remove Title
	~~Staff Attorney Sr~~	~~R~~	~~691~~	~~$144,000~~	~~$174,000~~		~~$204,000~~		Remove Title
	Supervisor Accounting	M	434	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Audit and Oversight	M	618	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Behavioral Health	M	659	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Budgeting	N	466	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Case Management	M	86	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Claims	~~I~~ J	219	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Regrade job; Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Coding Initiatives	M	502	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Credentialing	I	671	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Customer Service	I	34	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Data Entry	H	192	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Day Center (PACE)	H	619	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Dietary Services (PACE)	J	643	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Encounters	I	253	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Facilities	J	162	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
	Supervisor Finance	M	419	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.

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Supervisor Grievance and Appeals	L	620	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
~~Supervisor Information Services~~ Supervisor Information Technology Services	N	457	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Change Title; Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Long Term Support Services	M	587	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Member Outreach and Education	K	592	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor MSSP	M	348	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Nursing Services (PACE)	M	662	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor OneCare Customer Service	I	408	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Payroll	M	517	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Pharmacist	Q	610	$130,000	~~$157,000~~	$166,200	~~$184,000~~	$202,400	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Population Health Management	M	673	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Provider Data Management Services	K	439	$70,000	~~$84,000~~	$88,900	~~$98,000~~	$107,800	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Provider Relations	L	652	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Quality Analytics	M	609	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Quality Improvement	M	600	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Social Work (PACE)	J	636	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Therapy Services (PACE)	M	645	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Supervisor Utilization Management	M	637	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.
Systems Network Administrator Int	L	63	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Systems Network Administrator Sr	M	89	$85,000	~~$103,000~~	$109,050	~~$121,000~~	$133,100	Increase pay grade maximum by 10% and calculate midpoint.

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Systems Operations Analyst	F	32	$51,000	~~$59,000~~	$62,350	~~$67,000~~	$73,700	Increase pay grade maximum by 10% and calculate midpoint.
Systems Operations Analyst Int	G	45	$55,000	~~$63,000~~	$66,550	~~$71,000~~	$78,100	Increase pay grade maximum by 10% and calculate midpoint.
Technical Analyst Int	J	64	$65,000	~~$78,000~~	$82,550	~~$91,000~~	$100,100	Increase pay grade maximum by 10% and calculate midpoint.
Technical Analyst Sr	L	75	$77,000	~~$93,000~~	$98,450	~~$109,000~~	$119,900	Increase pay grade maximum by 10% and calculate midpoint.
Therapy Aide	E	521	$48,000	~~$55,000~~	$58,100	~~$62,000~~	$68,200	Increase pay grade maximum by 10% and calculate midpoint.
Training Administrator	I	621	$61,000	~~$73,000~~	$77,250	~~$85,000~~	$93,500	Increase pay grade maximum by 10% and calculate midpoint.
Training Program Coordinator	H	471	$59,000	~~$68,000~~	$71,850	~~$77,000~~	$84,700	Increase pay grade maximum by 10% and calculate midpoint.
Translation Specialist	B	241	$38,000	~~$44,000~~	$46,500	~~$50,000~~	$55,000	Increase pay grade maximum by 10% and calculate midpoint.
Web Architect	N	366	$95,000	~~$114,000~~	$120,650	~~$133,000~~	$146,300	Increase pay grade maximum by 10% and calculate midpoint.

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

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

Attachment A: CalOptima - Annual Base Salary Schedule (Revised: March 03, 2022)
To be implemented: March 13, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Accountant	H	39	$59,000	$71,850	$84,700
Accountant Int	I	634	$61,000	$77,250	$93,500
Accountant Sr	K	68	$70,000	$88,900	$107,800
Accounting Clerk	D	334	$44,000	$53,900	$63,800
Accounting Clerk Sr	E	680	$48,000	$58,100	$68,200
Activity Coordinator (PACE)	E	681	$48,000	$58,100	$68,200
Actuarial Analyst	K	558	$70,000	$88,900	$107,800
Actuarial Analyst Sr	L	559	$77,000	$98,450	$119,900
Actuary	O	357	$105,000	$134,450	$163,900
Actuary Principal	Q	TBD	$130,000	$166,200	$202,400
Actuary Sr	P	TBD	$117,000	$149,250	$181,500
Administrative Assistant	D	19	$44,000	$53,900	$63,800
Analyst	H	562	$59,000	$71,850	$84,700
Analyst Int	I	563	$61,000	$77,250	$93,500
Analyst Sr	J	564	$65,000	$82,550	$100,100
Applications Analyst	I	232	$61,000	$77,250	$93,500
Applications Analyst Int	J	233	$65,000	$82,550	$100,100
Applications Analyst Sr	L	298	$77,000	$98,450	$119,900
Associate Director I	P	TBD	$117,000	$149,250	$181,500
Associate Director II	Q	TBD	$130,000	$166,200	$202,400
Associate Director III	R	TBD	$144,000	$184,200	$224,400
Associate Director IV	S	TBD	$154,000	$204,600	$255,200
Auditor	I	565	$61,000	$77,250	$93,500
Auditor Sr	J	566	$65,000	$82,550	$100,100
Behavioral Health Manager	M	383	$85,000	$109,050	$133,100
Biostatistics Manager	M	418	$85,000	$109,050	$133,100
Board Services Specialist	E	435	$48,000	$58,100	$68,200
Business Analyst	J	40	$65,000	$82,550	$100,100
Business Analyst Sr	L	611	$77,000	$98,450	$119,900
Business Systems Analyst Sr	K	69	$70,000	$88,900	$107,800
Buyer	G	29	$55,000	$66,550	$78,100
Buyer Int	H	49	$59,000	$71,850	$84,700
Buyer Sr	I	67	$61,000	$77,250	$93,500
Care Manager	K	657	$70,000	$88,900	$107,800
Care Transition Intervention Coach (RN)	L	417	$77,000	$98,450	$119,900
Certified Coder	H	399	$59,000	$71,850	$84,700
Certified Coding Specialist	H	639	$59,000	$71,850	$84,700
Certified Coding Specialist Sr	J	640	$65,000	$82,550	$100,100
Change Control Administrator	I	499	$61,000	$77,250	$93,500
Change Control Administrator Int	J	500	$65,000	$82,550	$100,100
** Chief Compliance Officer	W	TBD	$313,000	$414,450	$515,900
** Chief Executive Officer	Z	138	$560,000	$700,750	$841,500
** Chief Financial Officer	X	134	$368,000	$487,600	$607,200
** Chief Health Equity Officer	W	TBD	$313,000	$414,450	$515,900
** Chief Human Resources Officer	W	TBD	$313,000	$414,450	$515,900
** Chief Information Officer	W	131	$313,000	$414,450	$515,900

Attachment A: CalOptima - Annual Base Salary Schedule (Revised: March 03, 2022)
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	Job Title	Pay Grade	Job Code	Min	Mid	Max
**	Chief Medical Officer	X	137	$368,000	$487,600	$607,200
**	Chief of Staff	U	TBD	$226,000	$298,900	$371,800
**	Chief Operating Officer	Y	136	$433,000	$573,450	$713,900
	Claims - Lead	G	574	$55,000	$66,550	$78,100
	Claims Examiner	C	9	$41,000	$49,650	$58,300
	Claims Examiner - Lead	F	236	$51,000	$62,350	$73,700
	Claims Examiner Sr	E	20	$48,000	$58,100	$68,200
	Claims QA Analyst	F	28	$51,000	$62,350	$73,700
	Claims QA Analyst Sr	G	540	$55,000	$66,550	$78,100
	Claims Recovery Specialist	F	283	$51,000	$62,350	$73,700
	Claims Resolution Specialist	F	262	$51,000	$62,350	$73,700
	Clerk of the Board	O	59	$105,000	$134,450	$163,900
	Clinical Auditor	L	567	$77,000	$98,450	$119,900
	Clinical Auditor Sr	M	568	$85,000	$109,050	$133,100
	Clinical Documentation Specialist (RN)	M	641	$85,000	$109,050	$133,100
	Clinical Pharmacist	P	297	$117,000	$149,250	$181,500
	Clinical Systems Administrator	K	607	$70,000	$88,900	$107,800
	Clinician (Behavioral Health)	K	513	$70,000	$88,900	$107,800
	Communications Specialist	G	188	$55,000	$66,550	$78,100
	Communications Specialist - Lead	J	TBD	$65,000	$82,550	$100,100
	Communications Specialist Sr	H	TBD	$59,000	$71,850	$84,700
	Community Partner	G	575	$55,000	$66,550	$78,100
	Community Partner Sr	H	612	$59,000	$71,850	$84,700
	Community Relations Specialist	G	288	$55,000	$66,550	$78,100
	Community Relations Specialist Sr	I	646	$61,000	$77,250	$93,500
	Compliance Claims Auditor	G	222	$55,000	$66,550	$78,100
	Compliance Claims Auditor Sr	H	279	$59,000	$71,850	$84,700
	Contract Administrator	K	385	$70,000	$88,900	$107,800
	Contracts Manager	M	207	$85,000	$109,050	$133,100
	Contracts Manager Sr	N	683	$95,000	$120,650	$146,300
	Contracts Specialist	I	257	$61,000	$77,250	$93,500
	Contracts Specialist Int	J	469	$65,000	$82,550	$100,100
	Contracts Specialist Sr	K	331	$70,000	$88,900	$107,800
*	Controller	T	464	$182,000	$240,600	$299,200
	Credentialing Coordinator	E	41	$48,000	$58,100	$68,200
	Credentialing Coordinator - Lead	F	510	$51,000	$62,350	$73,700
	Customer Service Coordinator	E	182	$48,000	$58,100	$68,200
	Customer Service Rep	C	5	$41,000	$49,650	$58,300
	Customer Service Rep - Lead	E	482	$48,000	$58,100	$68,200
	Customer Service Rep Sr	D	481	$44,000	$53,900	$63,800
	Data Analyst	J	337	$65,000	$82,550	$100,100
	Data Analyst Int	K	341	$70,000	$88,900	$107,800
	Data Analyst Sr	L	342	$77,000	$98,450	$119,900
	Data and Reporting Analyst - Lead	M	654	$85,000	$109,050	$133,100
	Data Entry Tech	A	3	$36,000	$43,300	$50,600
	Data Warehouse Architect	N	363	$95,000	$120,650	$146,300

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Data Warehouse Programmer/Analyst	N	364	$95,000	$120,650	$146,300
	Data Warehouse Reporting Analyst	M	412	$85,000	$109,050	$133,100
	Data Warehouse Reporting Analyst Sr	N	522	$95,000	$120,650	$146,300
	Database Administrator	L	90	$77,000	$98,450	$119,900
	Database Administrator Sr	N	179	$95,000	$120,650	$146,300
**	Deputy Chief Medical Officer	W	561	$313,000	$414,450	$515,900
	Deputy Clerk of the Board	K	684	$70,000	$88,900	$107,800
	Designer	K	387	$70,000	$88,900	$107,800
	Designer Sr	L	TBD	$77,000	$98,450	$119,900
*	Director I	Q	TBD	$130,000	$166,200	$202,400
*	Director II	R	TBD	$144,000	$184,200	$224,400
*	Director III	S	TBD	$154,000	$204,600	$255,200
*	Director IV	T	TBD	$182,000	$240,600	$299,200
	Enrollment Coordinator (PACE)	F	441	$51,000	$62,350	$73,700
	Enterprise Analytics Manager	O	582	$105,000	$134,450	$163,900
	Executive Administrative Services Manager	J	661	$65,000	$82,550	$100,100
	Executive Assistant	G	339	$55,000	$66,550	$78,100
	Executive Assistant to CEO	I	261	$61,000	$77,250	$93,500
**	Executive Director	U	TBD	$226,000	$298,900	$371,800
	Facilities & Support Services Coord - Lead	G	631	$55,000	$66,550	$78,100
	Facilities & Support Services Coordinator	E	10	$48,000	$58,100	$68,200
	Facilities & Support Services Coordinator Sr	F	511	$51,000	$62,350	$73,700
	Facilities Coordinator	E	438	$48,000	$58,100	$68,200
	Financial Analyst	J	51	$65,000	$82,550	$100,100
	Financial Analyst Sr	L	84	$77,000	$98,450	$119,900
	Financial Reporting Analyst	I	475	$61,000	$77,250	$93,500
	Grievance & Appeals Nurse Specialist	M	226	$85,000	$109,050	$133,100
	Grievance Resolution Specialist	F	42	$51,000	$62,350	$73,700
	Grievance Resolution Specialist - Lead	I	590	$61,000	$77,250	$93,500
	Grievance Resolution Specialist Sr	H	589	$59,000	$71,850	$84,700
	Health Coach	K	556	$70,000	$88,900	$107,800
	Health Educator	H	47	$59,000	$71,850	$84,700
	Health Educator Sr	I	355	$61,000	$77,250	$93,500
	Health Network Liaison Specialist (RN)	L	524	$77,000	$98,450	$119,900
	Health Network Oversight Specialist	K	323	$70,000	$88,900	$107,800
	HEDIS Case Manager	M	443	$85,000	$109,050	$133,100
	Help Desk Technician	E	571	$48,000	$58,100	$68,200
	Help Desk Technician Sr	F	573	$51,000	$62,350	$73,700
	Human Resources Assistant	D	181	$44,000	$53,900	$63,800
	Human Resources Business Partner	M	584	$85,000	$109,050	$133,100
	Human Resources Coordinator	F	316	$51,000	$62,350	$73,700
	Human Resources Representative	J	278	$65,000	$82,550	$100,100
	Human Resources Representative Sr	L	350	$77,000	$98,450	$119,900
	Human Resources Specialist	G	505	$55,000	$66,550	$78,100
	Human Resources Specialist Sr	H	608	$59,000	$71,850	$84,700
	Information Technology Services Coordinator	E	365	$48,000	$58,100	$68,200

Attachment A: CalOptima - Annual Base Salary Schedule (Revised: March 03, 2022)
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Job Title	Pay Grade	Job Code	Min	Mid	Max
Information Technology Services Project Manager	N	424	$95,000	$120,650	$146,300
Information Technology Services Project Manager Sr	O	509	$105,000	$134,450	$163,900
Information Technology Services Project Specialist	K	549	$70,000	$88,900	$107,800
Information Technology Services Project Specialist Sr	L	550	$77,000	$98,450	$119,900
Infrastructure Systems Administrator	F	541	$51,000	$62,350	$73,700
Infrastructure Systems Administrator Int	G	542	$55,000	$66,550	$78,100
Inpatient Quality Coding Auditor	I	642	$61,000	$77,250	$93,500
Intern	A	237	$36,000	$43,300	$50,600
Investigator Sr	I	553	$61,000	$77,250	$93,500
Kitchen Assistant	A	585	$36,000	$43,300	$50,600
Licensed Clinical Social Worker	J	598	$65,000	$82,550	$100,100
Litigation Support Specialist	K	588	$70,000	$88,900	$107,800
LVN (PACE)	K	533	$70,000	$88,900	$107,800
LVN Specialist	K	686	$70,000	$88,900	$107,800
Mailroom Clerk	A	1	$36,000	$43,300	$50,600
Manager Accounting	O	98	$105,000	$134,450	$163,900
Manager Actuary	R	453	$144,000	$184,200	$224,400
Manager Audit & Oversight	O	539	$105,000	$134,450	$163,900
Manager Behavioral Health	O	633	$105,000	$134,450	$163,900
Manager Business Integration	O	544	$105,000	$134,450	$163,900
Manager Case Management	P	270	$117,000	$149,250	$181,500
Manager Claims	O	92	$105,000	$134,450	$163,900
Manager Clinic Operations	N	551	$95,000	$120,650	$146,300
Manager Clinical Pharmacist	R	296	$144,000	$184,200	$224,400
Manager Coding Quality	N	382	$95,000	$120,650	$146,300
Manager Communications	N	398	$95,000	$120,650	$146,300
Manager Community Relations	N	384	$95,000	$120,650	$146,300
Manager Contracting	O	329	$105,000	$134,450	$163,900
Manager Creative Branding	M	430	$85,000	$109,050	$133,100
Manager Cultural & Linguistic	M	349	$85,000	$109,050	$133,100
Manager Customer Service	M	94	$85,000	$109,050	$133,100
Manager Electronic Business	N	422	$95,000	$120,650	$146,300
Manager Encounters	N	516	$95,000	$120,650	$146,300
Manager Environmental Health & Safety	N	495	$95,000	$120,650	$146,300
Manager Finance	O	148	$105,000	$134,450	$163,900
Manager Financial Analysis	P	356	$117,000	$149,250	$181,500
Manager Government Affairs	N	437	$95,000	$120,650	$146,300
Manager Grievance & Appeals	O	426	$105,000	$134,450	$163,900
Manager Human Resources	O	526	$105,000	$134,450	$163,900
Manager Information Technology Services	P	560	$117,000	$149,250	$181,500
Manager Long Term Support Services	O	200	$105,000	$134,450	$163,900
Manager Marketing & Enrollment (PACE)	N	414	$95,000	$120,650	$146,300
Manager Marketing & Outreach	M	687	$85,000	$109,050	$133,100
Manager Member Liaison Program	M	354	$85,000	$109,050	$133,100
Manager Member Outreach & Education	M	616	$85,000	$109,050	$133,100
Manager MSSP	O	393	$105,000	$134,450	$163,900

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Manager OneCare Clinical	P	359	$117,000	$149,250	$181,500
	Manager OneCare Customer Service	M	429	$85,000	$109,050	$133,100
	Manager Outreach & Enrollment	M	477	$85,000	$109,050	$133,100
	Manager PACE Center	N	432	$95,000	$120,650	$146,300
	Manager Population Health Management	N	674	$95,000	$120,650	$146,300
	Manager Process Excellence	O	622	$105,000	$134,450	$163,900
	Manager Program Implementation	N	488	$95,000	$120,650	$146,300
	Manager Provider Data Management Services	M	653	$85,000	$109,050	$133,100
	Manager Provider Network	O	191	$105,000	$134,450	$163,900
	Manager Provider Relations	M	171	$85,000	$109,050	$133,100
	Manager Purchasing	O	275	$105,000	$134,450	$163,900
	Manager QI Initiatives	M	433	$85,000	$109,050	$133,100
	Manager Quality Analytics	N	617	$95,000	$120,650	$146,300
	Manager Quality Improvement	N	104	$95,000	$120,650	$146,300
	Manager Regulatory Affairs and Compliance	O	626	$105,000	$134,450	$163,900
	Manager Reporting & Financial Compliance	O	572	$105,000	$134,450	$163,900
	Manager Strategic Development	O	603	$105,000	$134,450	$163,900
	Manager Utilization Management	P	250	$117,000	$149,250	$181,500
	Marketing and Outreach Specialist	F	496	$51,000	$62,350	$73,700
	Medical Assistant	C	535	$41,000	$49,650	$58,300
	Medical Authorization Asst	C	11	$41,000	$49,650	$58,300
	Medical Case Manager	L	72	$77,000	$98,450	$119,900
	Medical Case Manager (LVN)	K	444	$70,000	$88,900	$107,800
*	Medical Director	V	306	$266,000	$351,900	$437,800
	Medical Records & Health Plan Assistant	B	548	$38,000	$46,500	$55,000
	Medical Records Clerk	B	523	$38,000	$46,500	$55,000
	Medical Services Case Manager	G	54	$55,000	$66,550	$78,100
	Member Liaison Specialist	D	353	$44,000	$53,900	$63,800
	MMS Program Coordinator	G	360	$55,000	$66,550	$78,100
	Nurse Practitioner (PACE)	O	635	$105,000	$134,450	$163,900
	Occupational Therapist	L	531	$77,000	$98,450	$119,900
	Occupational Therapist Assistant	H	623	$59,000	$71,850	$84,700
	Office Clerk	A	335	$36,000	$43,300	$50,600
	OneCare Operations Manager	N	461	$95,000	$120,650	$146,300
	OneCare Partner - Sales	F	230	$51,000	$62,350	$73,700
	OneCare Partner - Sales (Lead)	G	537	$55,000	$66,550	$78,100
	OneCare Partner - Service	C	231	$41,000	$49,650	$58,300
	OneCare Partner (Inside Sales)	E	371	$48,000	$58,100	$68,200
	Outreach Specialist	C	218	$41,000	$49,650	$58,300
	Paralegal/Legal Secretary	I	376	$61,000	$77,250	$93,500
	Payroll Specialist	E	554	$48,000	$58,100	$68,200
	Payroll Specialist Sr	G	688	$55,000	$66,550	$78,100
	Performance Analyst	I	538	$61,000	$77,250	$93,500
	Personal Care Attendant	A	485	$36,000	$43,300	$50,600
	Personal Care Attendant - Lead	B	498	$38,000	$46,500	$55,000
	Personal Care Coordinator	C	525	$41,000	$49,650	$58,300

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Job Title	Pay Grade	Job Code	Min	Mid	Max
Personal Care Coordinator Sr	D	689	$44,000	$53,900	$63,800
Pharmacy Resident	G	379	$55,000	$66,550	$78,100
Pharmacy Services Specialist	C	23	$41,000	$49,650	$58,300
Pharmacy Services Specialist Int	D	35	$44,000	$53,900	$63,800
Pharmacy Services Specialist Sr	E	507	$48,000	$58,100	$68,200
Physical Therapist	L	530	$77,000	$98,450	$119,900
Physical Therapist Assistant	H	624	$59,000	$71,850	$84,700
Policy Advisor Sr	M	580	$85,000	$109,050	$133,100
Privacy Manager	N	536	$95,000	$120,650	$146,300
Privacy Officer	O	648	$105,000	$134,450	$163,900
Process Excellence Manager	N	529	$95,000	$120,650	$146,300
Program Assistant	C	24	$41,000	$49,650	$58,300
Program Coordinator	C	284	$41,000	$49,650	$58,300
Program Development Analyst Sr	K	492	$70,000	$88,900	$107,800
Program Manager	L	421	$77,000	$98,450	$119,900
Program Manager Sr	M	594	$85,000	$109,050	$133,100
Program Specialist	E	36	$48,000	$58,100	$68,200
Program Specialist Int	G	61	$55,000	$66,550	$78,100
Program Specialist Sr	I	508	$61,000	$77,250	$93,500
Program/Policy Analyst	I	56	$61,000	$77,250	$93,500
Program/Policy Analyst Sr	K	85	$70,000	$88,900	$107,800
Programmer	K	43	$70,000	$88,900	$107,800
Programmer Int	M	74	$85,000	$109,050	$133,100
Programmer Sr	N	80	$95,000	$120,650	$146,300
Project Manager	L	81	$77,000	$98,450	$119,900
Project Manager - Lead	M	467	$85,000	$109,050	$133,100
Project Manager Sr	N	105	$95,000	$120,650	$146,300
Project Specialist	E	291	$48,000	$58,100	$68,200
Project Specialist Sr	I	503	$61,000	$77,250	$93,500
Projects Analyst	G	254	$55,000	$66,550	$78,100
Provider Data Management Services Coordinator	D	12	$44,000	$53,900	$63,800
Provider Data Management Services Coordinator Sr	F	586	$51,000	$62,350	$73,700
Provider Enrollment Manager	G	190	$55,000	$66,550	$78,100
Provider Network Rep Sr	I	391	$61,000	$77,250	$93,500
Provider Network Specialist	H	44	$59,000	$71,850	$84,700
Provider Network Specialist Sr	J	595	$65,000	$82,550	$100,100
Provider Office Education Manager	I	300	$61,000	$77,250	$93,500
Provider Relations Rep	G	205	$55,000	$66,550	$78,100
Provider Relations Rep Sr	I	285	$61,000	$77,250	$93,500
Publications Coordinator	G	293	$55,000	$66,550	$78,100
QA Analyst	I	486	$61,000	$77,250	$93,500
QA Analyst Sr	L	380	$77,000	$98,450	$119,900
QI Nurse Specialist	M	82	$85,000	$109,050	$133,100
QI Nurse Specialist (LVN)	L	445	$77,000	$98,450	$119,900
Receptionist	B	140	$38,000	$46,500	$55,000
Records Manager	Q	TBD	$130,000	$166,200	$202,400

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	Job Title	Pay Grade	Job Code	Min	Mid	Max
	Recreational Therapist	H	487	$59,000	$71,850	$84,700
	Registered Dietitian	I	57	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance - Lead	L	630	$77,000	$98,450	$119,900
	Regulatory Affairs and Compliance Analyst	I	628	$61,000	$77,250	$93,500
	Regulatory Affairs and Compliance Analyst Sr	K	629	$70,000	$88,900	$107,800
	RN (PACE)	M	480	$85,000	$109,050	$133,100
	Security Analyst Int	M	534	$85,000	$109,050	$133,100
	Security Analyst Sr	N	474	$95,000	$120,650	$146,300
	Security Officer	B	311	$38,000	$46,500	$55,000
	SharePoint Developer/Administrator Sr	N	397	$95,000	$120,650	$146,300
	Social Worker	J	463	$65,000	$82,550	$100,100
	Social Worker Sr	K	690	$70,000	$88,900	$107,800
*	Sr Director	T	TBD	$182,000	$240,600	$299,200
	Sr Manager I	P	TBD	$117,000	$149,250	$181,500
	Sr Manager II	Q	TBD	$130,000	$166,200	$202,400
	Sr Manager III	R	TBD	$144,000	$184,200	$224,400
	Sr Manager IV	S	TBD	$154,000	$204,600	$255,200
	Supervisor Accounting	M	434	$85,000	$109,050	$133,100
	Supervisor Audit and Oversight	M	618	$85,000	$109,050	$133,100
	Supervisor Behavioral Health	M	659	$85,000	$109,050	$133,100
	Supervisor Budgeting	N	466	$95,000	$120,650	$146,300
	Supervisor Case Management	M	86	$85,000	$109,050	$133,100
	Supervisor Claims	J	219	$65,000	$82,550	$100,100
	Supervisor Coding Initiatives	M	502	$85,000	$109,050	$133,100
	Supervisor Credentialing	I	671	$61,000	$77,250	$93,500
	Supervisor Customer Service	I	34	$61,000	$77,250	$93,500
	Supervisor Data Entry	H	192	$59,000	$71,850	$84,700
	Supervisor Day Center (PACE)	H	619	$59,000	$71,850	$84,700
	Supervisor Dietary Services (PACE)	J	643	$65,000	$82,550	$100,100
	Supervisor Encounters	I	253	$61,000	$77,250	$93,500
	Supervisor Facilities	J	162	$65,000	$82,550	$100,100
	Supervisor Finance	M	419	$85,000	$109,050	$133,100
	Supervisor Grievance and Appeals	L	620	$77,000	$98,450	$119,900
	Supervisor Information Technology Services	N	457	$95,000	$120,650	$146,300
	Supervisor Long Term Support Services	M	587	$85,000	$109,050	$133,100
	Supervisor Member Outreach and Education	K	592	$70,000	$88,900	$107,800
	Supervisor MSSP	M	348	$85,000	$109,050	$133,100
	Supervisor Nursing Services (PACE)	M	662	$85,000	$109,050	$133,100
	Supervisor OneCare Customer Service	I	408	$61,000	$77,250	$93,500
	Supervisor Payroll	M	517	$85,000	$109,050	$133,100
	Supervisor Pharmacist	Q	610	$130,000	$166,200	$202,400
	Supervisor Population Health Management	M	673	$85,000	$109,050	$133,100
	Supervisor Provider Data Management Services	K	439	$70,000	$88,900	$107,800
	Supervisor Provider Relations	L	652	$77,000	$98,450	$119,900
	Supervisor Quality Analytics	M	609	$85,000	$109,050	$133,100
	Supervisor Quality Improvement	M	600	$85,000	$109,050	$133,100

Attachment A: CalOptima - Annual Base Salary Schedule (Revised: March 03, 2022)
To be implemented: March 13, 2022

Job Title	Pay Grade	Job Code	Min	Mid	Max
Supervisor Regulatory Affairs and Compliance	M	627	$85,000	$109,050	$133,100
Supervisor Social Work (PACE)	J	636	$65,000	$82,550	$100,100
Supervisor Therapy Services (PACE)	M	645	$85,000	$109,050	$133,100
Supervisor Utilization Management	M	637	$85,000	$109,050	$133,100
Systems Network Administrator Int	L	63	$77,000	$98,450	$119,900
Systems Network Administrator Sr	M	89	$85,000	$109,050	$133,100
Systems Operations Analyst	F	32	$51,000	$62,350	$73,700
Systems Operations Analyst Int	G	45	$55,000	$66,550	$78,100
Technical Analyst Int	J	64	$65,000	$82,550	$100,100
Technical Analyst Sr	L	75	$77,000	$98,450	$119,900
Therapy Aide	E	521	$48,000	$58,100	$68,200
Training Administrator	I	621	$61,000	$77,250	$93,500
Training Program Coordinator	H	471	$59,000	$71,850	$84,700
Translation Specialist	B	241	$38,000	$46,500	$55,000
Web Architect	N	366	$95,000	$120,650	$146,300

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

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

Policy:	GA.8057
Title:	**Compensation Program**
Department:	CalOptima Administrative
Section:	Human Resources
Interim CEO Approval:	*/s/ Richard Sanchez 06/10/2020*
Effective Date:	05/01/2014
Revised Date:	06/04/2020
Applicable to:	☐ Medi-Cal ☐ OneCare ☐ OneCare Connect ☐ PACE ☒ Administrative

I. PURPOSE

This policy establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;
2. Attract, retain, and motivate employees;
3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and
4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how the compensation procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.
2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and the pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations

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Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The CEO is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guidelines not inconsistent therewith.

III. PROCEDURE

Not Applicable

IV. ATTACHMENT(S)

A. Compensation Administration Guidelines

V. REFERENCE(S)

Not Applicable

VI. REGULATORY AGENCY APPROVAL(S)

None to Date

VII. BOARD ACTION(S)

Date	Meeting
05/01/2014	Regular Meeting of the CalOptima Board of Directors
08/07/2014	Regular Meeting of the CalOptima Board of Directors
11/06/2014	Regular Meeting of the CalOptima Board of Directors
12/04/2014	Regular Meeting of the CalOptima Board of Directors
03/05/2015	Regular Meeting of the CalOptima Board of Directors
06/04/2015	Regular Meeting of the CalOptima Board of Directors
06/07/2018	Regular Meeting of the CalOptima Board of Directors
06/04/2020	Regular Meeting of the CalOptima Board of Directors

VIII. REVISION HISTORY

Action	Date	Policy	Policy Title	Program(s)
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8057	Compensation Program	Administrative
Revised	06/07/2018	GA.8057	Compensation Program	Administrative
Revised	06/04/2020	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

Revised June 04, 2020

Implemented March 29, 2020

Contents

Pay Administration Guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These Guidelines help maintain the integrity of the base pay program by introducing a common set of standards and assist managers in ongoing compensation program administration.

In addition, note the following administration of the Guidelines:

- Chief Executive Officer (CEO) compensation will be established by the Board of Directors.
- Chief and Executive Director compensation will be established by the CEO within the Guidelines.
- The Board will be informed of all Chief and Executive Director hires and compensation changes.

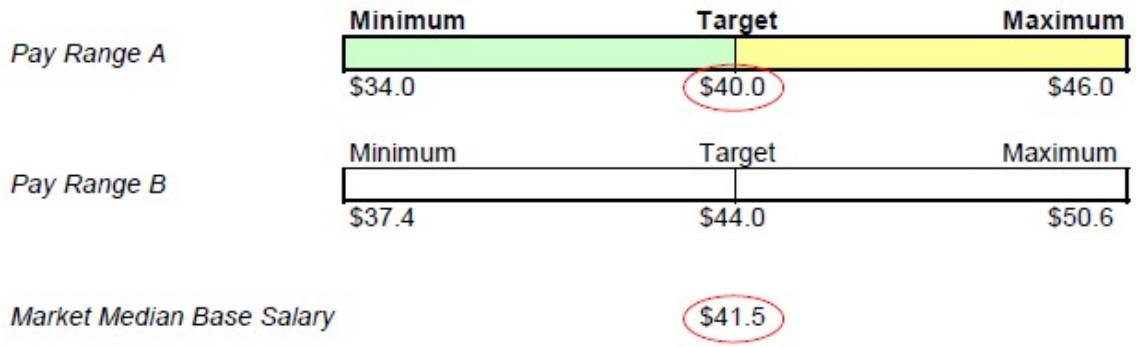
Proposed Pay Administration Guidelines

Pay ranges and pay levels	Pay range target Range minimums and maximums Pay above range maximums Pay range thirds Pay range halves Compa-ratio
Periodic pay adjustments/increases	New hire/Rehire Promotion Lateral Transfer Demotion Temporary Assignment Secondary job Job Re-evaluation Appeal Process Register/Certified Status Base pay program maintenance Salary structure adjustment Annual competitive assessment Market sensitive jobs
Annual pay adjustments/increases	Market Adjustment Merit pay Step increase
Special one-time pay considerations	Recruitment incentive

Pay Ranges and Pay Levels

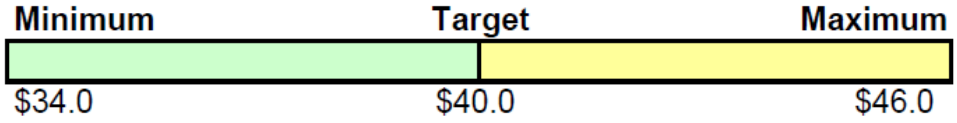
Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations.

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets.



Range Target $40.0 is Closest to Market Median of $41.5; job is assigned to Pay Range A

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact.



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations.

- All employees should have a pay rate equal to or greater than the pay range minimum.
- If the minimum job requirements are not met, a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months while a new incumbent is learning the skills to become proficient in the new role.

Range Maximum: represents the maximum rate paid to individuals who possess qualifications significantly above market norms and consistently deliver superior performance.

- Base pay growth is capped at the pay range maximum.

Pay Above Range Maximum: Employees are not paid above the range maximum.

- Employees whose current pay becomes above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases until such time as their base pay falls below the pay range maximum.

- In lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation.

- As the pay structures and pay ranges move every twelve (12) – thirty-six (36) months or as necessary, the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate.

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable, and appropriate pay levels

- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations.

- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate one hundred percent (100%) proficiency in all aspects of the job's duties, responsibilities and performance expectations.

- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills, or abilities that far surpass the market's typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities, and performance expectations.

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness.

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target.

- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate.

  - Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target.

  - Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target.

Illustrative Range Shown Below:

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Note: *Range minimums and maximums will be based on the developed salary range spreads.*

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range grades based on market pay practices.

- A market adjustment may result in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target).
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression.
- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum.
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%).
- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues.
- Market adjustments are made prior to determining merit pay.
- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target.

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment.

- Merit Pay: Merit pay is variable pay that typically affects employees' base pay; it recognizes employees' job proficiency and performance of job duties.
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay.
    - To be eligible for merit pay, the employee must have started work on or before March 31 to be eligible for a merit increase in July of the same year and have successfully completed the introductory period [three (3) months for transfers and new hires] prior to the annual pay adjustment date.
    - Merit pay will typically be an increase to base pay; however, it may also be delivered

as a one-time lump sum bonus for individuals paid above the pay range maximum.

- The budgeted amount for merit pay, if any, is based on 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues.

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity.
    - Merit pay is typically calculated as a percent of base pay in effect on March 31, prorated to reflect the number of months an employee worked during the twelve (12)-month period starting from the first pay period in the fiscal year and ending with the last pay period of that same fiscal year.
    - Managers have the discretion to determine the actual increase amount within the published Guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives.
    - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in two (2) incremental amounts- the first half when merit pay is normally distributed; and the second half six (6) months later.
    - Merit pay may be held altogether or delayed for ninety (90) days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record.
    - Merit pay is typically awarded once a year at a specific time.
    - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time.
    - Executive Directors and Chief's must approve merit pay increases for all areas for which they are responsible before submitting to HR.
    - HR has final approval of all merit increases.

A Merit Pay Grid similar to the one shown below [assumes a three percent (3%) merit increase budget] is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and

4. Recruiting and retention issues.

	Pay Range Position				
Performance Rating	**1st Quartile**	**2nd Quartile**	**3rd Quartile**	**4th Quartile**	**Above Max**
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%
Needs Improvement	0%	0%	0%	0%	0%

Above Max = Lump Sum Bonus

***The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.*

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay.

- The increase may be withheld altogether or delayed ninety (90) days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retroactive; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase.

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above.

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to fifteen percent (15%) of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima.
    - Recruitment incentives require the approval of the CEO.
    - Board approval is required for recruitment incentives offered to Executive Director and above positions.

Incentives are provided with a "pay-back" provision if the employee terminates within twenty four (24) months of hire.

New Hires/Rehires

- A new hire's pay level corresponds to the appropriate pay range quartile and typically should not exceed the pay range target. Offers above the pay range target require the approval of the Executive Director of Human Resources and the CEO, when necessary.

- Factors to be considered in determining an appropriate pay level for a new hire include:

    - Job-related experience: What is the estimated learning curve given the individual's prior work experience? How many years of experience does the individual have in the same or equivalent classification?

    - Market conditions: What is the going rate of pay in the external market for the individual's skills and knowledge?

    - Internal equity: Is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service.

    - For example, an RN having three (3) years of prior job experience is viewed comparably to an RN having three (3) years of job experience at CalOptima.

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions.

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications.

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate).

- Determine appropriate pay rate by assessing candidate's knowledge, skills, and experience, as well as pay rates currently being paid to similarly situated incumbents.

- Candidates with superior knowledge, skills, and experience can be paid above the pay range midpoint. Starting pay rates above the pay range midpoint must have approval of the Executive Director of Human Resources and CEO, when necessary.

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical).

- Pay rates for all positions are reviewed with the Compensation Unit before an offer is made. The Compensation Unit will review internal equity across the system to ensure that the appropriate offer is made.

- Rehires to the same classification should be paid at least the same amount they earned prior to termination, with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima.

- The above policy applies to the current organization structure.
- Additional positions at the level of Chief or Executive Director require Board approval.

Promotion

An employee receives a promotion when the employee applies for and is selected for a job with a higher pay range target.

- An employee will receive a promotional increase to at least the pay range minimum of the new pay range.
- The amount of a promotional increase will be determined based on the incumbent's qualifications, performance, and internal pay practices. The typical promotional increase for a promotion without external competition is up to five percent (5%) of the employee's base pay per one (1) pay grade increase.
- Typically, the promotional increase should not exceed the pay range target.
- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.
- Employees who are promoted after March 31, but prior to receiving their merit increase, will have their merit increase, if any, included in the base pay used to calculate their promotional pay. If the employee's performance evaluation rating and therefore merit increase amount is not known at the time the promotional pay is being calculated, a merit increase equivalent to "Fully Meets Expectations" will be included in the base pay used to calculate their promotional pay.
- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

It is considered a lateral transfer if an employee moves to a job having the same pay range target.

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Executive Director of Human Resources.
- Employees who are laterally transferred after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Demotion

An employee is classified as having been demoted if the employee moves to a job with a lower pay range target.

- The pay of an employee demoted due to an organizational restructure, will not be decreased unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.

- For an involuntary demotion, due to performance, or for a voluntary demotion, the pay grade of the demoted employee will be assigned to the pay grade of the employee's new classification. The employee's base pay will typically be reduced up to five percent (5%) for each pay grade demoted.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

- Employees who are demoted after March 31, but prior to receiving their merit increase, will typically have their merit pay calculated as a percent of their base pay in effect on March 31.

Temporary Assignment

An employee who is asked to assume a full-time temporary assignment in a job having a higher pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase.

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate.

- This increased secondary pay rate is eliminated when the temporary assignment ends.

- The amount of the temporary assignment increase should be consistent with the promotion policy.

Training/Transition Overlap

In order to provide for a transition and/or training period, CalOptima may fill a regular position with a replacement in advance of the separation of a terminating employee. For the transition and/or training period, two employees may fill the same budgeted position for up to thirty (30) calendar days during the period of overlap. The immediate supervisor will determine which employee will be designated for decision-making and regulatory reporting purposes, if applicable.

Job Re-Evaluations

Job re-evaluations will be reviewed in the following priority order:

1. New Positions.

2. Change of thirty-five percent (35%) or more of duties [any change in responsibilities less than thirty-five percent (35%) will not be considered].

    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification.

    - Additional duties that do not require the above will not be considered for reclassification.

    - All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Unit.

    - In the case of management positions being re-classified, the appropriate Chief must sign the documentation.

    - The request must include the incumbent's current job description and revised job description with enhancements highlighted.

    - The request must also include justification that the re-classification supports a business need.

If the job is determined to be a priority, the Compensation Unit will analyze the job according to:

1. The job's scope against other jobs in the same discipline.

2. Available market data.

3. Appropriate title identification. The Compensation Unit will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended.

4. Job family.

5. Fair Labor Standards Act (FLSA) status.

6. Appropriate pay grade – the job will be fit into one (1) of the pay grades that currently exists. No new pay grades created.

7. A pay rate will be determined.

8. A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager.

If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date. The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Unit. The amount of the pay increase should follow the guidelines in the Promotion section. If the upgrade and a pay change occur less than six (6) months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated.

If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources.

If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed.

If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed.

Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one (1) month of the request.

If a job is not a priority or does not meet the guidelines, the manager will be notified.

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness.
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate, and retain the workforce.
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data.
- Market adjustments will be applied to the salary schedule as needed at least every two (2) years, using surveyed salary structure adjustment percentages.
- The salary structure adjustment approval process includes:
    - The Executive Director of Human Resources makes a recommendation to the CEO for approval.
    - CEO takes the recommendation to the Board for final approval.

Annual Competitive Assessment

- On a regular basis either annually or every other year, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices.
    - CalOptima will on a regular basis either annually or every other year spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates.
    - Based on market findings, the pay grade and ranges will be updated.
    - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations.
- The results of these analyses, along with CalOptima's current financial performance and economic situation, will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets.
- The following criteria is typically used to determine which jobs to market price each year:
    - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues.
    - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and

expenses to identify jobs with potential recruiting issues.

- Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues.
- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%.
- Review all market-sensitive jobs and those on the "watch list."
- Review top ten (10) highest populated jobs on an annual basis.
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced.
- It is recommended that at least two (2) jobs be selected from every pay range.

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends.

- On a regular basis either annually or every other year, the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments.
- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process.
    - Adjustments to pay range minimums occur prior to merit pay calculations.

Process for Making Market Adjustments

- HR performs, on a regular basis either annually or every other year, a review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs.
- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues.
- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount.
- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.).

- HR identifies the cost implications for the market adjustment by identifying the difference between 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:

    - The Executive Director of Human Resources recommends an adjustment to the CEO for approval.

    - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the classification as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging.

- Premium pay is built into the pay range targets for these jobs.

    - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need.

    - The desired market target rate is established on a job-by-job basis to reflect specific market conditions.

- Criteria used to determine if a job is classified as market-sensitive typically includes two (2) or more of the following:

    - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions.

    - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates.

    - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last three (3) to six (6) months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs.

    - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:

        - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,

        - a competitive market rate significantly higher [approximately ten percent (10%)] than its current pay range target, or

        - a competitive market rate with significantly higher pay practices [approximately ten percent (10%)] in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.

    - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one (1) year.

    - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive, but are showing signs of becoming so are placed on a "watch list" and monitored.

If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

CalOptima Board Action Agenda Referral

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Authorize CalFresh Outreach Strategy to Enroll Eligible CalOptima Members into the CalFresh Program to Address Food Insecurity

Contacts

Michael Hunn, Interim Chief Executive Officer, (657) 900-1481
Rachel Selleck, Executive Director, Public Affairs, (657) 900-1096

Recommended Action

1. Authorize implementation of a CalFresh Outreach Strategy to promote enrollment of identified CalOptima members who are potentially eligible and not yet enrolled in the CalFresh program;
2. Authorize unbudgeted expenditures and appropriate up to $2,000,000 from existing reserves to implement the CalFresh Outreach Strategy; and
3. Authorize the Chief Executive Officer (CEO) to execute agreements for expenditures as necessary to implement proposed activities.

Background

The California Department of Health Care Services (DHCS) has received federal approval from the Centers for Medicare & Medicaid Services (CMS) on the California Advancing and Innovating Medi-Cal (CalAIM) waivers. This approval allows the State and managed care plans to implement a more integrated and whole person focused delivery model, including addressing social drivers of health.

During the pandemic, food insecurity was exacerbated for CalOptima members and the community at large. CalOptima, in collaboration with the Orange County Social Services Agency (SSA), identified approximately 344,000 CalOptima members (approximately 259,000 households) as potentially eligible, but not enrolled in CalFresh, a food benefits program administered locally by SSA. Through the CalFresh program, a single individual may be eligible for up to $250 per month in assistance and a family of four may be eligible for up to $835 per month.

To address food insecurity with CalOptima members, staff propose a CalFresh Outreach Strategy to encourage CalOptima member enrollment in CalFresh and educate CalOptima providers and community stakeholders about CalFresh. The goal is to have 100,000 CalOptima members who are eligible but not enrolled to join the CalFresh program by December 31, 2022.

Discussion

Staff recognizes that education, outreach, and enrollment in the CalFresh program requires a multi-prong approach with our members and providers. To address the needs and gaps identified in the Orange County safety net system, staff have developed CalOptima's CalFresh Outreach

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Strategy including:

- Establishing a warm-line transfer between CalOptima member-facing departments (e.g., Customer Service, Case Management and Population Health Management) and designated staff at SSA's CalFresh Call Center, for members identified by CalOptima as eligible for CalFresh;
- Direct member mailer;
- Outbound call campaign via contracted vendor;
- Text message campaign via contracted vendor;
- A series of CalFresh enrollment events at grocery stores, food banks and other targeted locations; and
- Developing and/or leveraging collateral materials and sharing widely via CalOptima's communication channels with all audiences (e.g., flyers, posters, toolkits).

Staff requests Board approval of the CalFresh Outreach Strategy to address the unmet health-related social need of food security among our members. This strategy will implement activities to educate CalOptima members, providers, community stakeholders and CalOptima staff about the CalFresh program to promote member enrollment in the program. Staff will provide your Board with routine updates on the enrollment progress. The total estimated cost for implementing these strategies is approximately $2 million. These are estimated costs only and final costs will be dependent on final vendor negotiations, event locations, and additional marketing costs.

The following table provides details on each activity:

Activities targeting 259,000 Households (344,000 members)	**Estimated Costs**
Print CalFresh flyers/posters	Up to $130,000
Member Mailer ▪ Fulfillment cost of a direct mailer ▪ First class mail	Up to $200,000
Call Campaign (cost estimate based on current contract pricing) ▪ 3 attempts to reach members ▪ Recorded line ▪ Secure consent to receive text messages as part of the call	Up to $1,000,000
Text Message Campaign • Unlimited one way texting, subject to approval by DHCS, to households who have provided consent (approx. 100k at this time)	Up to $200,000
CalFresh Enrollment Events (3-5 events) ▪ Cost for rentals, supplies, equipment, and logistics	Up to $150,000
Marketing ▪ Billboards in geo-targeted neighborhoods to reach members who are potentially eligible for CalFresh	Up to $275,000

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Total Estimated Costs	**$ 1,955,000**

Fiscal Impact

The recommended action is unbudgeted. An appropriation of up to $2,000,000 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima has prioritized food security as a Social Determinant of Health to address for CalOptima members. CalFresh provides an opportunity to support our members' access to food to support their overall health and well-being. While the CalFresh program is not a Medi-Cal covered benefit, healthcare providers, care coordinators, health educators, and other support staff may provide referrals to community resources such as CalFresh as part of overall care coordination and preventive services. Staff recommends implementation of this strategy and use of funds to support the implementation of the CalFresh Outreach Strategy.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Action
2. CalFresh Outreach Strategy

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Carenet Healthcare Services	11845 IH-10 West, Suite 400	San Antonio	TX	78230
County of Orange Social Services Agency	500 N. State College Blvd.	Orange	CA	92868
mPulse	16530 Ventura Blvd., Suite 500	Encino	CA	91436

CalOptima CalFresh Outreach Strategy

BACKGROUND/OPPORTUNITY

- OC Social Services Agency (SSA) data identified approximately **344,000** CalOptima members (approximately **259,000** distinct households) as potentially eligible for CalFresh and not currently enrolled as of December 2021
  - Note: A single individual **may be** eligible for up to $250 and a family of four **may be** eligible for up to $835 per month
- A warm transfer process has been established between CalOptima Customer Service and SSA
  - CR will test warm line transfer
  - Will pilot the warm line transfer process with PHM when materials have been developed and approved

GOALS/OBJECTIVES

Goal: Increase CalFresh enrollment by 100,000 CalOptima members by December 31, 2022

Objectives:

1. Launch targeted member-facing outreach campaign to increase CalOptima members' awareness and enrollment in CalFresh to address food insecurity
2. Partner with CalOptima Health Networks, Providers and Community Based Organizations
3. Educate member-facing CalOptima staff and CalOptima to encourage CalFresh enrollment

TACTICS

COLLATERAL DEVELOPMENT

Flyers

- Update the existing CalOptima CalFresh collateral to align with campaign
- Develop enrollment flyer

Posters

- Update and/or leverage SSA CalFresh poster to align with campaign for providers and CBOs

Toolkits

- Develop and/or leverage toolkits from SSA for providers and CBOs

Other collateral materials:

- Scripts for CalOptima staff, providers and Carenet
- Member direct mailer

To support development of messages, scripts and key concepts for campaign:

- Internal focus group with Customer Service, PHM, CM, PR and CR scheduled for 2/7
- Gathered community/member feedback on 2/2
- Will connect with PAC for provider feedback
- Will connect with MAC for community feedback

DIGITAL/WEB DEVELOPMENT

Landing Page/Portal Content

- Develop dedicated landing page on the public-facing CalOptima website, Member and Provider portals with audience-specific information

Social Media Promotion

- Organic and paid posts/advertisements (targeted)

TARGETED MEMBER OUTREACH

CalFresh Direct Mailer

- Mail to target populations in-language with a focus on the following populations:
  - Children and families, older adults and members with chronic conditions such as congestive heart failure, COPD, coronary artery, diabetes, hypertension and obesity

CalFresh Enrollment Events

- Host series of CalFresh Enrollment Events in cities with the lowest CalFresh enrollment and enroll members [with Social Services Agency and/or community enrollers (10 total)]
  - Include community resources such as free diapers (Tom Tom Diaper Stork), food distribution (Second Harvest or Community Action Partnership)
  - Promote services provided by CalOptima's Population Health Management program and CalFresh Healthy Living
    - CalFresh Healthy Living live demonstrations throughout the day

Outreach calls via CalOptima member-facing departments and contracted vendor*

- Customer Service, Case Management and Population Health Management to promote CalFresh with identified eligible members
- 344,000 potentially eligible members will be flagged in Facets and GuidingCare
- CareNet to provide outbound calls to priority groups including children and families, older adults and members with chronic conditions (54k households with 1 chronic conditions and 34k households with 2+ chronic conditions)
  - **Action:** amend CareNet contract at March BoD

Text messaging campaign

- Bi-monthly in-language texts with call to action. Drive visits to landing page on CalOptima website, invitation to member-specific virtual information sessions about CalFresh
  - **Action:** confirm with Legal COVID emergency provision can be leveraged to distribute CalFRESH messaging via text without 'opt-in'

GENERAL COMMUNICATIONS

Member Newsletters

- Dedicated CalFresh article. Publication produced quarterly.

New Member Packets

- Include CalFresh information in CalOptima's new member packets.

Health Fairs and Vaccine Clinic Distribution

- Distribute CalFresh information wherever CalOptima maintains a presence.

- CalOptima/SSA distribute CalFresh information at food distribution events/centers and SSA provide enrollment at these events

CalFresh Information Sessions

- Offer in English, Spanish and Vietnamese in April
- Record sessions and post on CalOptima website for follow-up promotional opportunities.

Community Announcements

- CalFresh-specific articles distributed to approximately 2700+ stakeholders

Provider Monthly Update/Health Network Weekly Communication (email)

- Include CalFresh information in monthly newsletter and weekly HN emails

MEDIA RELATIONS

Press Releases:

- Announcing launch of campaign and key elements
- Second release mid-campaign to re-energize and comment on status
- Close-out release announcing results
- Highlight Member and Provider success stories

Op-Ed:

- CMO authored Op-Ed regarding food insecurity as a social determinant of health

Event Media

- Pitch media around CalFresh Enrollment Events

ESTIMATED BUDGET/BOARD 'ASK'

Activities targeting 259,000 Households (344,000 members)	**Estimated Costs**
Print CalFresh flyers/posters	Up to $130,000
Member Mailer ▪ Fulfillment cost of a direct mailer ▪ First class mail	Up to $200,000
Call Campaign (cost estimate based on current contract pricing) ▪ 3 attempts to reach members ▪ Recorded line ▪ Secure consent to receive text messages as part of the call	Up to $1,000,000
Text Message Campaign • Unlimited one way texting, subject to approval by DHCS, to households who have provided consent (approx. 100k at this time)	Up to $200,000
CalFresh Enrollment Events (3-5 events) ▪ Cost for rentals, supplies, equipment, and logistics	Up to $150,000
Marketing ▪ Billboards in geo-targeted neighborhoods to reach members who are potentially eligible for CalFresh	Up to $275,000
Total Estimated Costs	**$ 1,955,000**

TIMELINE

TACTIC	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN
Collateral Development												
Direct Mailer												
Web/Portal Updates												
Outreach Calls												
Text Messaging												
Social Media Promotion												
Community Announcements												
Member Newsletter				Spring			Summer					
CalFresh Information Session (member audience)												
CalFresh Information Session (CBO audience)												
Provider Monthly Update (email)												
HN Weekly Communication												
CalFresh Enrollment Events												
Press Release												
Op-Ed												

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Approve Amendment VIII to the Kaiser Foundation Health Plan Inc. Contract for Health Care Services, for the Medi-Cal COVID-19 Vaccination Incentive Program

Contacts

Yunkyung Kim, Chief Operating Officer, (714) 246-8408
Marie Jeannis, Executive Director of Quality & Population Health Management, (714) 246-8591

Recommended Actions

Approve Amendment VIII to the Kaiser Foundation Health Plan Inc. (Kaiser) Health Maintenance Organization (HMO) Medi-Cal Contract for Health Care Services, to include language supporting the COVID-19 Vaccine Incentive Program and vaccination incentive payments, effective April 1, 2022.

Background and Discussion

Staff seek approval to amend Kaiser's Medi-Cal contract to provide an incentive to participate in the Medi-Cal COVID-19 Vaccination Incentive Program.

In September 2021, the Department of Health Care Services (DHCS) launched the "Medi-Cal COVID-19 Vaccination Incentive Program". Under the program, DHCS allocated $350 million for Medi-Cal Managed Care Plans (MCPs) to incentivize COVID-19 vaccination efforts for the period September 1, 2021, through February 28, 2022. The DHCS Medi-Cal COVID-19 Vaccination Incentive Program incentive methodology includes the following:

- Maximum incentive funds are based on the MCP's share of Medi-Cal membership;
- 20% of the incentive award is based on submission and approval of a Vaccination Response Plan; and
- 80% of the incentive award is based on achievement of vaccination target goals, measured at the following intervals: October 31, 2021, January 2, 2022, and March 6, 2022.

Prior to the launch of DHCS's program, the CalOptima Board of Directors (Board) had authorized supplemental payments to CalOptima providers to support COVID-19 vaccination and testing efforts. As Kaiser is the only fully delegated health network and contracted under a unique payment structure, these supplemental payments have not applied to Kaiser. Instead, staff propose to share CalOptima's vaccine incentive earned dollars proportional to Kaiser's membership where CalOptima has determined Kaiser independently met the DHCS Medi-Cal COVID-19 Vaccination Incentive Program goals.

Except as amended in the proposed amendment, Kaiser's HMO Medi-Cal health network contract will remain in full force for its full term. To ensure Kaiser members' improved access to COVID-19 vaccinations and care, staff requests the Board authorize Amendment VIII to Kaiser's Medi-Cal HMO Contract for Health Care Services, effective April 1, 2022.

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Fiscal Impact

There is no additional fiscal impact to the recommended action. Kaiser's payment is contingent on CalOptima's receipt of funding from DHCS and Kaiser independently meeting the DHCS Medi-Cal COVID-19 Vaccination Incentive Program goals. As applicable, CalOptima will distribute vaccine incentive earned dollars to Kaiser proportional to Kaiser's delegated Medi-Cal membership.

Rationale for Recommendation

Amendment VIII to Kaiser's HMO health network contract will ensure continued quality improvement efforts targeting increased COVID-19 vaccinations for CalOptima's Kaiser members.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Entities Covered by this Recommended Board Action
2. Previous Board Action dated October 7, 2021: "Consider Authorizing Kaiser Foundation Health Plan Inc.'s Collaboration in Mutually Identified Quality Initiatives Including Participation in CalOptima's Quality Improvement Committee
3. APL 21-010; "Medi-Cal COVID-19 Vaccination Incentive Program"
4. Kaiser Amendment VIII for Vaccination Incentive Program [Proposed]

/s/ Michael Hunn *02/24/2022*
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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 7, 2021
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Authorizing Kaiser Foundation Health Plan, Inc.'s Collaboration in Mutually Identified Quality Initiatives Including Participation in CalOptima's Quality Improvement Committee

Contacts

Emily Fonda, Chief Medical Officer (714) 246-8887
Marie Jeannis, Executive Director, Quality & Population Health Management (714) 246-8591

Recommended Actions

Authorize the Chief Executive Officer (CEO)to request that Kaiser Foundation Health Plan, Inc. (Kaiser) collaborate with CalOptima on mutually identified quality initiatives through the following:

1. Participating in CalOptima's Quality Improvement Committee (QIC) on a quarterly basis (minimum); and
2. Collaboration on areas of focus with sharing of best practices and strategies. This collaboration will occur a minimum of quarterly or more often as needed. The areas of focus include:
    a. Poorly Controlled Diabetes
    b. Lead Screening in Children
    c. Prenatal and Postpartum Care
    d. Well Child Visits
    e. Member Experience
    f. COVID-19 Vaccination Response Plan.

Background

On June 3, 2021, the CalOptima Board of Directors (Board) directed staff to extend Kaiser's contract under the current capitation model, subject to the development and inclusion of specific quality improvement goals, that support Members' overall quality of care. In response to the Board's directive, CalOptima staff has worked with Kaiser to amend the contract and added the following language:

- "6.23 QUALITY INITIATIVE PARTICIPATION---HMO shall fully participate in those CalOptima quality elements/initiatives as may, from time to time, be adopted by the CalOptima Board of Directors and be mutually agreed upon by HMO and CalOptima, including the timely submission of all data and reports associated with such quality initiatives, to improve overall health outcomes."

To support the contract amendment and quality initiative goals, staff proposes additional collaboration with Kaiser focused on mutually agreed upon key quality strategic measures which include both clinical quality measures and member experience measures.

Staff notes that Kaiser is a fully delegated health network, and as such has its own quality program.

Discussion

As part of CalOptima's oversight responsibilities, management proposes to request Kaiser's participation in CalOptima's QIC meetings effective the fourth quarter of 2021.
Kaiser's participation in the QIC will allow greater collaboration between the two entities, an opportunity to share prevailing practices, and result enhanced services for our members.

CalOptima and Kaiser representatives met on August 13, 2021 and discussed opportunities to collaborate on mutually identified goals. Kaiser agreed to participate in CalOptima's QIC meetings and collaborate on areas of focus with sharing of best practices and strategies.

The QIC is the foundation of the QI program and is accountable to the Quality Assurance Committee (QAC). Quality initiatives identified through the QIC will be reported up to the QAC for strategic direction and recommendations. QAC routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives and quality performance results achieved. The QAC also makes recommendations to the Board for annual approval with modifications and appropriate resource allocations of the QI Program.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted delegated entities to achieve the result of improved care and services for members. The QIC oversees the performance of delegated functions by its delegated partners and their contracted provider and practitioner partners. The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts to ensure that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to QI Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC. The QIC also recommends strategies for quality initiatives and current QI work plan activities to CalOptima's delegated partners.

To assist CalOptima in continuing to deliver positive outcomes and quality care for our members, staff proposes Kaiser's attendance at the QIC on a quarterly basis beginning next quarter, and to periodically report on the status of Kaiser's quality programs and initiatives. The QIC reports to the QAC of the Board of Directors and provides progress reports on quality initiatives and quality performance results achieved. The QAC provides additional strategic direction and guidance. Kaiser's QIC activities and participation will be included in the staff's management report for the QAC. The QAC Kaiser Management Report would be separate from the current QIC report and would provide progress reports on CalOptima and Kaiser mutual collaborative efforts and initiatives.

In addition, CalOptima proposes Kaiser to collaborate on mutually identified areas of focus. The areas of focus include:

1. Poorly Controlled Diabetes
2. Blood Lead Screening in Children
3. Prenatal and Postpartum Care
4. Well Child Visits
5. Member Experience
6. COVID-19 Vaccination Response Plan.

Through a Kaiser specific quality meeting, CalOptima and Kaiser will collaborate on mutually identified quality initiatives to understand and identify health inequities or disparities. Quality initiatives will target areas such as comprehensive diabetes care (particularly focusing on members with poor HbA1c control), blood lead screening for children, prenatal and postpartum care, well child visits, improved member experience, and vaccination plan for COVID-19.

In support of the Board's directive to include quality initiative requirements, staff recommends authorization to request Kaiser's participation in QIC meetings and collaboration on mutually identified quality initiatives and sharing best practices.

Staff will return to the Board with further recommendations on any additional Kaiser-specific deliverables and/or performance metrics as needed.

Fiscal Impact

The recommended action to request Kaiser to collaborate with CalOptima on mutually identified quality initiatives is operational in nature and has no additional fiscal impact beyond what was incorporated in the CalOptima Fiscal Year 2021-22 Operating Budget approved by the CalOptima Board of Directors on June 3, 2021. The existing funding under the Kaiser contract is inclusive of funding for participation and collaboration on quality initiatives.

Rationale for Recommendation

Staff recommends Board authorization of these actions to ensure continued quality care for our members and support greater collaboration between CalOptima and Kaiser.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Entities Covered by this Recommended Action

/s/ Richard Sanchez *9/30/2021*
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

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

WILL LIGHTBOURNE
DIRECTOR

GAVIN NEWSOM
GOVERNOR

DATE: September 1, 2021

ALL PLAN LETTER 21-010 *(Revised)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: MEDI-CAL COVID-19 VACCINATION INCENTIVE PROGRAM

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide guidance to Medi-Cal managed care health plans (MCPs) regarding the Medi-Cal COVID-19 Vaccination Incentive Program. For the purposes of this APL, MCPs include Cal MediConnect Medicare-Medicaid Plans (MMPs). Revised text is found in *italics*.

BACKGROUND:
As of *August 8*, 2021, *48.7* percent of Medi-Cal beneficiaries ages 12 years and older compared with *73.7* percent of all Californians ages 12 years and older have received at least one dose of a COVID-19 vaccine. Approximately 14 million Californians are enrolled in Medi-Cal, including individuals from diverse racial and ethnic groups, those with complex care needs, seniors and persons with disabilities, those who live in rural/frontier communities, individuals experiencing homelessness, refugee and immigrant communities, those dually eligible for Medicare and Medi-Cal, and other individuals who may be hard to reach or face health disparities.

MCPs are responsible for managing care for the vast majority of Medi-Cal beneficiaries. As part of their contractual obligations, MCPs are required to provide case management and care coordination for members, making them well positioned to provide enhanced coordination services, partner with primary care providers, pharmacies and other trusted community partners, and conduct outreach for vaccine distribution for their members, including harder-to-reach populations.

The Department of Health Care Services (DHCS) is allocating up to $350 million to incentivize COVID-19 vaccination efforts in the Medi-Cal managed care delivery system for the service period of September 1, 2021 through February 28, 2022 (“performance period”). MCPs are eligible to earn incentive payments for activities that are designed to close vaccination gaps with their enrolled members. Participating MCPs will develop Vaccination Response Plans to improve vaccine access and to develop the infrastructure to support this work in the long term. DHCS is seeking Centers for Medicare and Medicaid Services (CMS) approval for this program in accordance with 42 Code of Federal Regulations (CFR) section 438.6(b)(2), but will go live at the state’s risk

even if CMS approval is still pending. Terms of the program may be modified to obtain CMS approval.

POLICY:
Effective September 1, 2021, participating MCPs may be eligible to participate in the Medi-Cal COVID-19 Vaccination Incentive Program.

MCP Eligibility and Participation
MCP participation in this incentive program is voluntary, but strongly encouraged. MCPs that elect to participate must adhere to program and applicable federal and state requirements in order to earn incentive payments.

All MCPs, including Cal MediConnect MMPs, are eligible to participate, except the following:

- Family Mosaic Project;
- Programs of All-Inclusive Care for the Elderly;
- Rady Children's Hospital San Diego (California Children's Services pilot program); and
- MCPs that are not primarily responsible for physical health care, such as county Mental Health Plans and Dental Managed Care Plans.

Impacted and Focus Populations
This incentive program covers all MCP members who are not fully vaccinated against COVID-19. This includes members who received the first dose of a multi-dose vaccine prior to September 1, 2021, but not *subsequent recommended doses*.

To assist Primary Care Providers and, if applicable, other local partners as needed with outreaching to their assigned members, MCPs must share the data provided by DHCS on their unvaccinated members.

DHCS has identified some populations of focus served by MCPs who have been disproportionately challenged in the initial phases of vaccine distribution and take-up. These include members who:

- Are homebound and unable to travel to vaccination sites;
- Are 50-64 years of age with *one or more* chronic diseases;
- Self-identify as persons of color; and
- Are youth 12-25 years of age.

MCPs are encouraged to consider strategies particularly for, but not limited to, these populations of focus. As information and strategies evolve, DHCS may identify additional populations of focus.

Incentive Program Structure
The incentive program is designed to encourage MCPs to attain specific performance measures that include both process and outcome measures. The maximum amount of MCP incentive payments that may be earned by all MCPs for these measures is $250 million. The maximum incentive amount that each individual MCP is eligible to earn will be established in proportion to the MCP's enrolled membership relative to total Medi-Cal managed care enrollment, as determined by DHCS and subject to the requirement of 42 CFR 438.6(b)(2) that incentive payments not exceed five percent of the value of capitation payments attributable to the enrollees or services covered by the incentive arrangement. Additionally, there will be a $100 million pool of funds available for MCPs to utilize for direct member incentives (e.g., $50 gift card to grocery store) as part of the MCP's Vaccination Response Plan.

To fully meet the vaccine needs of members, the measures will allow MCPs to earn incentives for increasing outreach efforts to underserved communities, building and monitoring data systems, and coordinating with regional partners to ensure all members have equitable access to vaccines, regardless of demographic factors such disability, race, and/or ethnicity. See the Process and Outcome Measures section below for details regarding MCP incentive structures.

Vaccination Response Plan
Participating MCPs are required to develop a Vaccination Response Plan, and submit this plan to DHCS for review and approval. MCP Vaccination Response Plan submissions are due no later than September 1, 2021. DHCS will review MCP Vaccination Response Plan submissions on a rolling and expedited basis. This Vaccination Response Plan must be broad reaching, but must consider the outcome measures and prioritize impacted and focus populations as described above. MCPs must specifically identify strategies for collaborating and supporting organizations, which include but are not limited to community-based organizations, trusted local partners, tribal partners, community health workers, promotoras, pharmacies, local health departments, and faith-based partnerships, in their Vaccination Response Plans to increase vaccine uptake success. MCPs must also identify strategies to ensure homebound members are contacted, that opportunities to receive the vaccine are identified, and coordination activities to receive the vaccine are implemented. MCPs must report to DHCS on their activities under the Vaccine Response Plan at the program's conclusion.

DHCS has developed a Vaccination Response Plan Template that contains the required components of the Vaccination Response Plan, which MCPs are required to use. DHCS will provide this template via email upon initial issuance of this APL; however, MCPs can request a copy of this template by emailing mcqmd@dhcs.ca.gov. *MCPs must*

submit their Vaccination Response Plans on the template to mcqmd@dhcs.ca.gov by September 1, 2021.

Process and Outcome Measures

MCPs collectively may earn up to $250 million, statewide, for achieving specified process and outcome measures. Please refer to Attachment A for outcome measures.

- Process Measure (20%)
  - MCPs may earn 20% of their maximum incentive allocation, as determined by DHCS, for development and submission of a Vaccination Response Plan that addresses all of the components listed in the Vaccination Response Plan Template and is approved by DHCS.
  - MCPs must submit their Vaccination Response Plan to DHCS by September 1, 2021, and all Vaccination Response Plans must have a start or implementation date no later than September 21, 2021.
  - Payment to each MCP will be made following DHCS' approval of its Vaccination Response Plan.

- Outcome Measures (80%)
  - MCPs may earn 80% of their maximum incentive amount for achievement of outcomes measures specified by DHCS. Please refer to Attachment A for the structure of the payment as tied to specific outcomes measures and further details regarding each outcome measures.
  - Partial payments will be made available for MCPs that make some progress in improving vaccination rates but do not meet pre-specified endpoints for full payment.
  - DHCS will make incentive payments on a schedule to be determined DHCS. Payments will be based on achievement of specified outcome measures.

Direct Member Vaccine Incentives

There will be a $100 million pool of funds available for MCPs to utilize for direct member incentives (e.g., $50 gift card to grocery store). In order to draw funds from the direct member incentive pool, MCPs must attest to meeting specified requirements and include their direct member incentive strategy in their Vaccination Response Plan. See the Vaccination Response Plan Template for specified requirements that MCPs must meet to draw funds from the direct member incentive pool. MCPs that elect to offer direct member incentives must comply with applicable state and federal requirements, including but not limited to the U.S. Department of Health and Human Services Office of

the Inspector General guidance related to offering or providing a reward or incentive in connection with a beneficiary receiving a COVID-19 vaccine.[1]

Payment and Other Considerations
DHCS will issue payment for process and outcome measures upon approving the MCP's Vaccination Response Plan and assessing achievement of outcomes at three intervals: as of October 31, 2021, January 2, 2022, and March 6, 2022.

As a condition of participation, MCPs will be expected to report to DHCS all available data and information that DHCS deems to be necessary to evaluate the MCP's performance on specified incentive program measures and for the disbursement of funds from the direct member incentive pool. Additional guidance related to the reporting schedule and requirements for progress being made on achieving the outcome measures, as well as for the direct member incentive pool, are forthcoming.

Incentive payments earned by MCPs under this program, as well as expenses directly associated with a MCP's participation in this program including but not limited to administrative costs and costs of direct member incentives, must be excluded from all applicable risk mitigation calculations. In addition, these incentive payments must be independent of, and must not interact with, the application of savings percentages and quality withholds to capitation rates for Cal MediConnect MMPs.

Member Outreach
DHCS requests MCPs to outreach to members using all communication mechanisms. Calls and text messages are exempt from the Telephone Consumer Protection Act (TCPA) under a COVID-19 exemption if they meet the following requirements: [2,3]

- The caller must be from a hospital, or be a health care provider, state or local health official, or other government official, as well as a person under the express direction of such an organization and acting on its behalf.
- The content of the call must be:
    - Solely informational;
    - Made necessary because of the COVID-19 outbreak; and

[1] See Frequently Asked Questions – Application of the Office of Inspector General's Administrative Enforcement Authorities to Arrangements Directly Connected to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency at: https://oig.hhs.gov/coronavirus/authorities-faq.asp
[2] See Telephone Consumer Protection Act of 1991, Pub. L. No. 102-243, 105 Stat. 2394 (1991), codified at 47 U.S.C. Section 227, available at: https://www.govinfo.gov/content/pkg/USCODE-2011-title47/pdf/USCODE-2011-title47-chap5-subchapII-partI-sec227.pdf.
[3] See FCC Public Notice, Consumer and Governmental Affairs Bureau Clarification on Emergency COVID-19 Related Calls, DA 20-793.

- Directly related to the imminent health or safety risk arising out of the COVID-19 outbreak.

Based on guidance in the Federal Communications Commission (FCC) notice, the rise in COVID-19 cases across California poses a significant and imminent health and safety risk for all state citizens, including Medi-Cal beneficiaries. To address the surge in COVID-19 cases, DHCS is requesting that MCPs conduct outreach to their members regarding the availability of COVID-19 vaccines; the goal of these outreach campaigns is to increase vaccine rates to stop the spread of COVID-19.

MCPs may use calls and text messages that meet the requirements of the TCPA COVID-19 exemption as part of this outreach campaign. As a reminder, texting campaigns related to COVID-19 can be submitted as File and Use only if the MCP has previously received approval on a texting campaign (as of June 18, 2019, forward). If prior approval has not been given, the MCP must submit the texting campaign template for review and approval prior to implementing the campaign. Please refer to the March 30, 2020, email from DHCS related to texting flexibilities. DHCS will prioritize and expedite the review of MCP File and Use texting campaign request submissions.

MCPs may submit their vaccine outreach campaign member materials to DHCS under the File and Use flexibility set forth in APL 20-004. DHCS will make every effort to review and approve submissions expeditiously. *MCPs may use vaccine materials developed by the California Department of Public Health (CDPH) without undergoing DHCS review.*[4]

[4] *CDPH-developed materials are available on DHCS' COVID-19 Response webpage, located at: https://www.dhcs.ca.gov/Pages/DHCS-COVID%E2%80%9119-Response.aspx*.

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.[5] 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 Bambi Cisneros

Bambi Cisneros, Acting Chief
Managed Care Quality and Monitoring Division

[5] For more information on Subcontractors and Network Providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

AMENDMENT VIII TO
CONTRACT FOR HEALTH CARE SERVICES

THIS AMENDMENT VIII TO THE CONTRACT FOR HEALTH CARE SERVICES ("Amendment") is effective as of April 1, 2022, by and between Orange County Health Authority, a Public Agency, dba CalOptima ("CalOptima"), and, Kaiser Foundation Health Plan, Inc. ("HMO"), with respect to the following facts:

RECITALS

A. CalOptima and HMO have entered into the Amended and Restated Contract for Health Care Services, effective July 1, 2019, ("Contract"), by which HMO has agreed to provide or arrange for the provision of Covered Services to Members.

B. CalOptima and HMO desire to amend the Contract to include a COVID-19 Vaccine Incentive Program for Members who are not fully vaccinated against COVID-19.

NOW, THEREFORE, the parties agree as follows:

1. Attachment E-8, "Medi-Cal COVID-19 Vaccination Incentive Program", shall be added to the Contract, is attached hereto, and incorporated into the Contract by this reference.

2. CONTRACT REMAINS IN FULL FORCE AND EFFECT – Except as specifically amended by this Amendment, all other conditions contained in the Contract shall continue in full force and effect. After the effective date of this Amendment, any reference to the Contract shall mean the Contract as amended and supplemented by this Amendment. Notwithstanding anything to the contrary in the Contract, in the event of a conflict between the terms and conditions of this Amendment and those contained within the Contract, the terms and conditions of this Amendment shall prevail. Capitalized terms not otherwise defined in this Amendment shall have the meanings ascribed to them in the Contract. This Amendment is subject to approval by the Government Agencies and by the CalOptima Board of Directors.

[signature page follows]

IN WITNESS WHEREOF, Orange County Health Authority d/b/a CalOptima and Kaiser Foundation Health Plan, Inc. have executed this Amendment:

FOR HMO:	FOR CALOPTIMA:
SIGNATURE	SIGNATURE
PRINT NAME	PRINT NAME
TITLE	Chief Operating Officer TITLE
DATE	DATE

Attachment E-8

Medi-Cal COVID-19 Vaccination Incentive Program

This Attachment E-8 sets forth an incentive program for the COVID-19 vaccine, as authorized by the CalOptima Board of Directors at its March 3, 2022, meeting.

Program Overview:

HMO shall receive incentive program payments for meeting Process Measures and Outcome Measures, as detailed in this Attachment E-8 for the period of September 1, 2021, through February 28, 2022, if the following conditions are met:

- CalOptima achieves the Process and Outcome Measure target goals;
- CalOptima receives incentive payment from DHCS; and
- HMO achieves the Process and Outcome Measure target goals.

Subject to the above conditions, HMO shall receive incentive payment proportional to HMO's CalOptima Medi-Cal enrollment.

Process Measure:

HMO may earn 20% of its maximum incentive allocation if it:

- Submits its Vaccination Response Plan to CalOptima no later than September 1, 2021;
- The Vaccination Response Plan is approved by DHCS; and
- The Vaccination Response Plan is implemented no later than September 21, 2021.

CalOptima agrees to make a payment to HMO for meeting the Process Measure conditions within forty-five (45) business days from receipt of Process Measure incentive funds from DHCS.

Outcome Measures:

HMO may earn 80% of its maximum incentive allocation if it meets the following target goals:

1. Intermediate Outcome Measures:

Category	Measurement Criteria	Weight	Total Weight	Target Measurement Goals
Homebound	Percent of homebound Medi-Cal beneficiaries who received at least one dose of a COVID-19 vaccine	**5%**	**10%**	**HMO's targets will be as follows:** • By October 31, 2021, a 10% increase over the

Primary Care Providers	Percent of primary care providers in HMO providing COVID-19 vaccine in their office	**5%**		HMO's baseline rate • By January 2, 2022, a 20% increase over the HMO's baseline rate • By March 6, 2022, a 30% increase over the HMO's baseline rate

*HMO shall only receive incentive payment for the two intermediate outcome measures selected by CalOptima.

2. Vaccine Uptake Outcome Measures:

Category	Measurement Criteria	Weight	Total Weight	Target Measurement Goals
Overall vaccine uptake	Percent of Medi-Cal beneficiaries ages 12 years and older who received at least one dose of a COVID-19 vaccine	**35%**	**35%**	**Gap closure is from baseline in group**. This would be the county rate. Gap closure for vaccine uptake outcome measures all categories: **Full Payment** HMO would need to close 33.3% of the gap between its baseline rate and the above-defined target rate by October 31, 2021; 66.6% of the gap between its baseline rate and the target rate by January 2, 2022; and 100% of the gap between its baseline rate and the target rate by March 6, 2022.
Age group	Percent of Medi-Cal beneficiaries ages 12-25 years who received at least one dose of a COVID-19 vaccine	**10%**	**25%**	
	Percent of Medi-Cal beneficiaries ages 26-49 years who received at least one dose of a COVID-19 vaccine	**5%**		
	Percent of Medi-Cal beneficiaries ages 50-64 years who received at least one dose of a COVID-19 vaccine	**5%**		
	Percent of Medi-Cal beneficiaries ages 65+ years who received at least one dose of a COVID-19 vaccine	**5%**		
Race/ ethnicity	Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the lowest	**15%**		

	baseline vaccination rate who received at least one dose of a COVID-19 vaccine - **Black**		**30%**	
	Percent of Medi-Cal beneficiaries ages 12 years and older from the race/ethnicity group with the second-lowest baseline vaccination rate who received at least one dose of a COVID-19 vaccine - **Native American**	**15%**		
		100%	**100%**	

*Payment will be based on performance on **all** the vaccine uptake outcome measures, calculated by DHCS and weighted as indicated.

HMO shall provide the following documentation and data to support that outcome measure goals have been met:

- DHCS data specific to Orange County; or
- Completed CalOptima reporting template.

CalOptima agrees to make a payment to the HMO within forty-five (45) business days from receipt of the final Outcome Measures incentive funds from DHCS.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
23. Authorize Contract with Moss Adams LLP for Independent Financial Auditing Services

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into contract with Moss Adams LLP for independent financial auditing services effective the contract execution date through March 3, 2025, with two one-year extension options.

Background and Discussion
CalOptima released a Request for Proposal (RFP) for CalOptima's independent financial auditing services in October 2021. The RFP Evaluation Team performed internal evaluations of the applicants' proposals. The weighted scores were as follows:

Vendor	Weighted Score
Moss Adams LLP	25.1
Vasquez & Company LLP	19.7

In December 2021, the RFP Evaluation Team conducted interviews with selected respondents and recommended Moss Adams LLP as the top-rated firm based on an objective scoring criteria and interviews.

Fiscal Impact
The estimated annual impact is approximately $216,000. Management will include expenses related to the contract in the FY 2022-2023 and future operating budgets.

Rationale for Recommendation
Staff recommends entering into the contract with Moss Adams LLP based on the results of the RFP. Moss Adams LLP was a top-ranked firm based on the evaluation criteria with strong healthcare industry experience.

Concurrence
James Novello, Outside General Counsel, Kennaday Leavitt

Attachments
1. Entities covered by this Recommended Board Action
2. Contract No. 22-10461 Between CalOptima and Moss Adams LLP

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

Back to Agenda

ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

CalOptima				
Name	**Address**	**City**	**State**	**Zip Code**
Moss Adams LLP	2040 Main Street, Suite 900	Irvine	CA	92614

CONTRACT NO. 22-10461
BETWEEN
ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY, dba
ORANGE PREVENTION & TREATMENT INTEGRATED MEDICAL ASSISTANCE, dba
CALOPTIMA
And
MOSS ADAMS LLP
(CONTRACTOR)

THIS CONTRACT ("Contract") is made and entered into as of the date last signed below, by and between the Orange County Health Authority, dba CalOptima, a public agency, hereinafter referred to as "CalOptima" and MOSS ADAMS LLP, hereinafter referred to as "CONTRACTOR." CalOptima and CONTRACTOR shall be referred to herein collectively as the "Parties" or individually as a "Party."

RECITALS

A. CalOptima desires to retain a CONTRACTOR to provide Financial Auditing Services, as described in the Scope of Work; and

B. CONTRACTOR provides such services; and

C. CONTRACTOR represents and warrants that it has the requisite personnel and experience and is capable of performing such services; and

D. CONTRACTOR desires to perform these services for CalOptima; and

E. CalOptima and CONTRACTOR desire to enter into this Contract on the terms and conditions set forth herein below.

NOW, THEREFORE, in consideration of their mutual and respective promises, and subject to the terms and conditions hereinafter set forth, the Parties agree as follows:

1. Documents Constituting Contract. This Contract shall include the following documents ("Contract Documents"), in the order of descending precedence: (i) this Contract, inclusive of all its exhibits and attachments, and any amendments thereto; (ii) CalOptima's Request for Proposal ("RFP"), 22-025, inclusive of any revisions, amendments and addenda thereto; (iii) CONTRACTOR's best and final offer dated 12/15/2021, and; (iv) CONTRACTOR's proposal dated 11/6/2021. Any new terms and conditions attached to CONTRACTOR's best and final offer, proposal, invoices, or request for payment, shall not be incorporated into the Contract Documents or be binding upon CalOptima unless expressly accepted by CalOptima in writing. All documents attached to this Contract and/or referenced herein as a "Contract Document" are incorporated into this Contract by this reference, with the same force and effect as if set forth herein in their entirety. Changes hereto shall not be binding upon CalOptima except when specifically confirmed in writing by an authorized representative of CalOptima and issued in accordance with Section 17, Modifications, herein. In the event of any conflict of provisions among the documents constituting the Contract, the provisions shall prevail in the above-referenced descending order of precedence.

2. Statement of Work.

2.1 CONTRACTOR shall perform the work necessary to complete, in a manner satisfactory to CalOptima, and if applicable, to the Centers for Medicare and Medicaid Services ("CMS"), the California Department of Health Care Services ("DHCS"), and/or the California Department of Managed Health Care ("DMHC"), as applicable, the services set forth in Exhibit A entitled "Scope of Work," which is attached hereto and incorporated herein by this reference. CONTRACTOR shall also perform in accordance with its Proposal dated 11/9/2021, and supplemental other information submitted to CalOptima on 12/15/2021, consisting of best and final offer.

2.2 CONTRACTOR shall provide the personnel listed below to perform the above-specified services, which persons are hereby designated as key personnel under this Contract. CONTRACTOR may replace such personnel who become sick, disabled, on official leave of absence, or who are no longer affiliated with CONTRACTOR. No person named in this Section 2, or his/her successor approved by CalOptima, shall be removed or replaced by CONTRACTOR, nor shall his/her agreed-upon function or level of commitment hereunder be changed without the prior written consent of CalOptima which consent shall not be unreasonably withheld. Should CONTRACTOR need to replace someone listed, CONTRACTOR shall provide the replacements name and any other information CalOptima deems reasonably necessary to be able to approve the replacement as qualified.

Name	Function/Title
Chris Pritchard	Partner and Quality Control Review
Stacy Stelzriede	Engagement Partner
Aparna Venkateswaran	Engagement Reviewer
Kristen Olko	Engagement Senior Manager
Ashley Merda	Engagement Senior
Taylor Korman	Engagement Senior

3. Insurance.

3.1 Prior to undertaking performance of services under this Contract and at all times during performance hereunder, and entirely at CONTRACTOR's sole expense, CONTRACTOR shall maintain the following insurance, which shall be full-coverage insurance not subject to self-insurance provisions, and CONTRACTOR shall not of its own initiative cause such insurance to be canceled or materially changed during the term of this Contract:

3.1.1 Required Insurance:

3.1.1.1 Commercial General Liability, including Contractual liability and coverage for Independent Contractors on an occurrence basis on an ISO form GC 00 01 or equivalent covering bodily injury and property damage with the following minimum liability limits:

3.1.1.2 Per Occurrence: $1,000,000

3.1.1.3 Personal Advertising Injury: $1,000,000

3.1.1.4 Products Completed Operations: $2,000,000

3.1.1.5 General Aggregate: $2,000,000

3.1.2 Commercial Automobile Liability covering any auto, whether owned, leased, hired, or rented, on an ISO form CA 0001 or equivalent in the amount of $1,000,000 combined single limit for bodily injury or property damage.

3.1.3 Workers' Compensation and Employers' Liability Policy written in accordance with the laws of the State of California and providing coverage for all of CONTRACTOR's employees:

3.1.3.1 This policy must provide statutory coverage for Workers' Compensation.

3.1.3.2 This policy must also provide coverage for $1,000,000 Employers' Liability for each employee, each accident, and in the general aggregate.

3.1.4 Professional Liability insurance covering the CONTRACTOR's professional errors and omissions with the following minimum limits of insurance:

3.1.4.1 Per occurrence: $1,000,000

3.1.4.2 General aggregate: $2,000,000

3.1.5 Commercial crime policy covering employee theft and dishonesty, forgery and alteration, money orders and counterfeit currency, credit card fraud, wire transfer fraud, and theft of client property, with the following minimum limits of $1,000,000 per occurrence:

3.1.5.1 Cyber and Privacy Liability insurance with the following minimum limits of insurance covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. Such coverage is required only if any products and/or services related to information technology (including hardware and/or software) are provided to Insured and for claims involving any professional services for which CONTRACTOR is engaged with Insured for such length of time as necessary to cover any and all claims.

a) Privacy and Network Liability: $1,000,000

b) Internet Media Liability: $1,000,000

c) Business Interruption & Expense: $1,000,000

d) Data Extortion: $1,000,000

e) Regulatory Proceeding: $1,000,000

f) Data Breach Notification & Credit Monitoring: $1,000,000

3.2 Prior to commencement of any work hereunder, CONTRACTOR shall furnish to CalOptima's Purchasing Department additional insured endorsements (blanket endorsement acceptable) and also broker-issued Certificate(s) of Insurance showing the required insurance coverages for CONTRACTOR, and further providing that:

Certificate Requirements:

3.2.1 CalOptima's officers, officials, directors, employees, agents, and volunteers are to be covered as additional insureds (blanket endorsement acceptable) with respect to liability arising out of work or operations performed by or on behalf of CONTRACTOR including materials, parts, or equipment furnished in connection with such work or operations. This provision applies to CONTRACTOR's General Liability and Auto Liability policies and must be on ISO form CG 20 10 or equivalent.

3.2.2 For any claims related to this contract, the CONTRACTOR's insurance coverage shall be primary insurance as respects to CalOptima, its officers, officials, directors, employees, agents, and volunteers. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers' Liability policies.

3.2.3 The Insurance Company agrees to waive all rights of subrogation against CalOptima and its elected or appointed officers, officials, directors, agents, and employees for losses paid under the terms of any policy which arise from work performed by the CONTRACTOR

for CalOptima. This provision applies to the CONTRACTOR's General Liability, Auto Liability and Workers' Compensation and Employers Liability policies.

3.2.4 Insurance is to be placed with insurers with a current A.M. Best rating of no less than A-VII, unless otherwise acceptable to CalOptima.

3.2.5 CONTRACTOR shall furnish CalOptima with original certificates and amendatory endorsements affecting coverage required by this clause. All certificates and endorsements are to be received and approved by CalOptima before work commences. CalOptima reserves the right to require complete, certified copies of all required insurance policies (with redacted declarations pages), including endorsements affecting the coverage required by these specifications, at any time.

3.2.6 All deductibles and retentions that the aforementioned policies contain are the responsibility of the CONTRACTOR and in no way shall CalOptima be responsible for payment of the deductibles/retentions.

3.2.7 If CONTRACTOR maintains higher limits than the minimums required above, CalOptima requires and shall be entitled to coverage for the higher limits maintained by CONTRACTOR. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to CalOptima.

3.2.8 Thirty (30) days prior written notice of cancellation be given to CalOptima.

3.3 If CONTRACTOR fails or refuses to maintain or produce proof of the insurance required by this Section 3, CalOptima shall have the right, at its election, to terminate forthwith this Contract. Such termination shall not affect CONTRACTOR'S right to be paid for its time and materials expended prior to notification of termination.

3.4 The requirement for carrying the required insurance shall not derogate from the provisions for indemnification of CalOptima.

3.5 CONTRACTOR shall require each of its subcontractors who perform services related to this Contract, if any, to maintain insurance coverage that meets all of the requirements set forth herein.

3.6 "Occurrence," as used herein, means any event or related exposure to conditions that result in bodily injury or property damage.

4. Indemnification.

4.1 To the fullest extent permitted by law, CONTRACTOR agrees to and shall save, defend, indemnify, and hold harmless CalOptima and its respective officers, directors, agents, volunteers, consultants and employees (individually and collectively referred to as "Indemnified Parties") from and against any liability (i) tangible personal property damage, bodily injury, or death to the extent arising from or related to the performance of CONTRACTOR, its officers, employees. subcontractors, agents, or representatives (individually and collectively referred to as "Indemnitors"); and (ii) third party claims arising solely from Indemnitors' negligent acts, errors or omissions or willful misconduct in its performance of services under the Contract. Notwithstanding the foregoing, or anything to the contrary in this Contract, CONTRACTOR'S obligations set forth in this Paragraph 4.1 shall not apply to any liability, loss, expense or claims for damages arising in whole or in part out of the negligent acts, errors or omissions or willful misconduct of CalOptima or any Indemnified Party. CONTRACTOR shall defend the Indemnified Parties in any claim or action based upon any such alleged acts or omissions, at its sole expense, which shall include all costs and fees, including, but not limited to, attorneys' fees, cost of investigation, defense, and settlement or awards. In the event of a claim for which

CalOptima may seek indemnification hereunder, CalOptima shall provide CONTRACTOR with prompt written notice of such claim and cooperate with CONTRACTOR in handling the claim. The CONTRACTOR shall be entitled to control the handling of such claim for which CalOptima may seek indemnification hereunder and to defend or settle any such claim, in its sole discretion, with counsel of its choosing. CalOptima will be entitled to participate in (but not control) the defense of any such third party claim or proceeding, with its counsel and at its own expense.

4.2 CONTRACTOR's obligation to indemnify hereunder is in addition to any liability CONTRACTOR may have to CalOptima for a breach by CONTRACTOR of any of the provisions of this Contract. Under no circumstances shall the insurance requirements and limits set forth in this Contract be construed to limit CONTRACTOR's indemnification and duty to defend obligation or other liability hereunder. The terms of this Contract are contractual and the result of negotiation between the Parties hereto. Accordingly, any rule of construction of contracts (including, without limitation, California Civil Code Section 1654) that ambiguities are to be construed against the drafting party, shall not be employed in the interpretation of this Contract.

4.3 CONTRACTOR's duty to defend herein is wholly independent of and separate from the duty to indemnify and such duty to defend shall exist regardless of any ultimate liability of CONTRACTOR, save and except Claims arising through the sole negligence or sole willful misconduct of CalOptima.

4.4 It is expressly understood and agreed that the foregoing provisions are intended to be as broad and inclusive as permitted by the law of the State of California and that CONTRACTOR's indemnification and duty to defend obligation hereunder shall survive the expiration or earlier termination of this Contract until such time as action against the Indemnified Parties for such matter indemnified hereunder is fully and finally barred by the applicable statute of limitations, including but not limited to those set forth under the California Government Claims Act (Cal. Gov. Code §900 et seq.).

4.5 It is not the intent of the Parties that the provisions of this Section and the Indemnification provision(s) set forth in the Business Associate Protected Health Information Disclosure Agreement executed by the Parties shall be in conflict. In the event of any conflict, the Indemnification provision(s) in the Business Associate Protected Health Information Disclosure Agreement shall be interpreted to relate only to matters within the scope of that Agreement.

4.6 The terms of this Section shall survive the termination of this Contract.

5. Independent Contractor. CalOptima and CONTRACTOR agree that CONTRACTOR, which term shall include any and all subcontractors, and any agents or employees of the CONTRACTOR, in performance of this Contract, shall act in an independent capacity, and not as officers or employees of CalOptima. CONTRACTOR's relationship with CalOptima in the performance of this Contract is that of an independent contractor. CONTRACTOR's personnel performing services under this Contract shall be at all times under CONTRACTOR's exclusive direction and control, and shall be employees of CONTRACTOR and not employees of CalOptima. CONTRACTOR shall pay all wages, salaries and other amounts due its employees in connection with this Contract, and shall be responsible for all reports and obligations respecting them, such as social security, income tax withholding, unemployment compensation, workers' compensation, and similar matters. At CONTRACTOR's expense as described herein, CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees as provided herein arising out of CONTRACTOR's alleged failure to pay, when due, all such taxes and obligations (collectively referred to for purposes of this paragraph as "Employment Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Employment Claim(s) as they are incurred by CalOptima.

6. Assignments; Subcontracts.

6.1 Except as specifically permitted hereunder, CONTRACTOR may not assign, transfer, delegate or subcontract any interest herein, either in whole or in part, without the prior written consent of CalOptima, which consent may be withheld in its sole and absolute discretion. In the event CalOptima provides such prior written consent, CONTRACTOR acknowledges and agrees that such assignment, transfer, delegation, or subcontract may additionally be subject to the prior written approval of DHCS. Any assignment, transfer, delegation, or subcontract made without CalOptima's express written consent shall be deemed void.

6.2 For purposes of this Section and this Contract, assignment is: (1) the change of more than twenty-five percent (25%) of the ownership or equity interest in CONTRACTOR (whether in a single transaction or in a series of transactions); (2) the change of more than twenty-five percent (25%) of the directors or trustees of CONTRACTOR (whether in a single transaction or in a series of transactions); (3) the merger, reorganization, or consolidation of CONTRACTOR with another entity with respect to which CONTRACTOR is not the surviving entity; and/or (4) a change in the management of CONTRACTOR from management by persons appointed, elected or otherwise selected by the governing body of CONTRACTOR (e.g. the Board of Directors) to a third-party management person, company, group, team or other entity.

6.3 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR shall, upon request, provide copies of such subcontracts to CalOptima or DHCS.

7. Non-Exclusive Relationship. It is understood by the parties that this is a non-exclusive relationship between CalOptima and CONTRACTOR. CalOptima shall have the right to have any of the services that are the subject of this Contract performed by CalOptima personnel or enter into contractual arrangements with one or more contractors who can provide CalOptima with similar or like services.

8. Compliance with Applicable Law and Policies. CONTRACTOR warrants that, in the performance of this Contract, it shall, at its own expense, observe and comply with all applicable federal, state, and local laws, and CalOptima Policies (provided to us) relating to services under the Contract that are in effect when this Contract is signed or which may come into effect during the term of this Contract.

9. Nondiscrimination Clause Compliance.

9.1 During the performance of this Contract, CONTRACTOR and its subcontractor(s) 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 Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), mental disability, medical condition (including cancer), age (over 40), marital status, and the use of family and medical care leave and pregnancy disability leave. CONTRACTOR and subcontractor(s) shall insure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment. CONTRACTOR and subcontractor(s) shall comply with the provisions of the Fair Employment and Housing Act (Government Code, Section 12900 et seq. and the applicable regulations promulgated thereunder Title 2, CCR, Section 7285.0 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990 (a-f), set forth in Chapter 5 of Division 4, Title 2, CCR are incorporated into this Contract by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractor(s) shall give notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. CONTRACTOR shall also fully comply with the following, to the extent applicable to the services provided by CONTRACTOR under this Contract: Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d (race, color, national origin); Section 504 of the Rehabilitation Act of 1973 (29 USC §794) (nondiscrimination

under Federal grants and programs); Title 45 CFR Part 84 (nondiscrimination on the basis of handicap in programs or activities receiving Federal financial assistance); Title 28 CFR Part 36 (nondiscrimination on the basis of disability by public accommodations and in commercial facilities); Title IX of the Education Amendments of 1973 (regarding education programs and activities); Title 45 CFR Part 91 and the Age Discrimination Act of 1975 (nondiscrimination based on age); as well as California Government Code Section 11135 (ethnic group identification, religion, age, sex, color, physical or mental handicap); California Civil Code Section 51 (all types of arbitrary discrimination); and all rules and regulations promulgated pursuant thereto.

9.2 CONTRACTOR shall include the nondiscrimination and compliance provisions of Section 9 in all subcontracts under this Contract.

10. Prohibited Interest.

10.1 CONTRACTOR shall comply with all applicable federal, state, and local laws and regulations pertaining to conflict of interest laws, including but not limited to CalOptima's Conflict of Interest Code, the California Political Reform Act (Government Code Section 81000 et seq.) and Government Code Section 1090 et seq. (collectively, the "Conflict of Interest Laws").

10.2 CONTRACTOR covenants that, for the term of the Contract, no director, officer, or employee of CalOptima during his tenure has any interest, direct or indirect, in this Contract or the proceeds thereof. CONTRACTOR further covenants that, for the term of this Contract, and consistent with the provisions of Title 22 California Code of Regulations (CCR) Section 53600(f), no state officer or state employee shall be employed in a management or contractor position by CONTRACTOR within one year after the state office or state employee has terminated state employment.

10.3 No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have foreseeable impact on CONTRACTOR if a conflict of interest, real or implied, exists. Such a conflict arises when any of the following has a financial or other interest in the firm selected for award:

10.3.1 A CalOptima employee, officer or agent;

10.3.2 Any member of the employee, officer or agent's immediate family;

10.3.3 The employee, officer or agent's domestic or business partner; and

10.3.4 An organization that employs or is about to employ any of the above.

10.4 CONTRACTOR understands that, if this Contract is made in violation of Government Code Section 1090 et seq., the entire Contract is voidable and CONTRACTOR will not be entitled to any compensation for Services performed pursuant to this Contract and CONTRACTOR will be required to reimburse CalOptima any sums paid to CONTRACTOR. CONTRACTOR further understands that, in addition to the foregoing, CONTRACTOR may be subject to criminal prosecution for a violation of Government Code Section 1090.

10.5 If CONTRACTOR hereinafter becomes aware of any facts, which might reasonably be expected to either create a conflict of interest under the Conflict of Interest laws or violate the provisions of this Section, CONTRACTOR shall immediately make full written disclosure of such acts to CalOptima. Full written disclosure shall include, without limitation, identification of all persons, entities and businesses implicated and a complete description of all relevant circumstances.

11. Disclosure of Officers, Owners, Stockholders and Creditors. On an annual basis and within thirty (30) days of any changes, CONTRACTOR shall identify the names of the following persons by listing them on Exhibit I, attached hereto and incorporated by this reference:

11.1 All officers and owners who own greater than 5% of the CONTRACTOR; and

11.2 All stockholders owning greater than 5% of any stock issued by CONTRACTOR.

11.3 All creditors of CONTRACTOR's business if such interest is over 5%.

12. Equal Opportunity.

12.1 CONTRACTOR and its Subcontractors 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 and its Subcontractors 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 and its Subcontractors agree to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or Department of Health Care Services ("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 U.S.C. 4212). Such notices shall state CONTRACTOR and its Subcontractors' 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.

12.2 CONTRACTOR and its Subcontractors will, in all solicitations or advancements for employees placed by or on behalf of CONTRACTOR and its Subcontractors, 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.

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

12.4 CONTRACTOR and its Subcontractors 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 U.S.C. 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 part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

12.5 CONTRACTOR and its Subcontractors 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 part 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.

12.6 In the event of CONTRACTOR and its Subcontractors' noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Contract may be cancelled, terminated, or suspended in whole or in part, and CONTRACTOR and its Subcontractors 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 part 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.

12.7 CONTRACTOR and its Subcontractors will include the provisions of this section in every subcontract or 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 part 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 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or CONTRACTOR. CONTRACTOR and its Subcontractors will take such action with respect to any subcontract or 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 and its Subcontractors become involved in, or are threatened with litigation by a subcontractor or CONTRACTOR as a result of such direction by DHCS, CONTRACTOR and its Subcontractors 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.

13. Standard of Performance; Warranties.

13.1 CONTRACTOR agrees to perform all work under this Contract with the requisite skill and diligence consistent with professional standards for the industry and type of work performed under this Contract, and pursuant to the governing rules and regulations of the industry.

13.2 In the event that CONTRACTOR is allowed to subcontract for services under this Contract, and does so subcontract, then CONTRACTOR represents and warrants that any individual or entity acting as a subcontractor to this Contract has the appropriate skill and expertise to perform the subcontracted work.

13.3 CONTRACTOR expressly warrants that all material and work will conform to applicable specifications, drawings, description and samples, including, without limitation, CalOptima's designs, drawings, and specifications, and will be merchantable, of good workmanship and material, and free from defect. CONTRACTOR further warrants that all material covered by this Contract, if any, which is the product of CONTRACTOR will be new and unused unless otherwise specified, and shall be fit and sufficient for the purpose intended by CalOptima, as disclosed to CONTRACTOR, CONTRACTOR shall promptly make whatever adjustments or corrections that may be necessary to cure any defects, including repairs of any damage to other parts of the system resulting from such defects. CalOptima shall give notice to CONTRACTOR of any observed

defects. In the event that CONTRACTOR fails to make adjustments, repairs, corrections, or other work made necessary by such defects, CalOptima may do so and charge CONTRACTOR the costs incurred.

13.4 CONTRACTOR's obligations under this Section are in addition to CONTRACTOR's other express or implied warranties and other obligations under this Contract or state law, and in no way diminish any other rights that CalOptima may have against CONTRACTOR for faulty materials, equipment or work. CalOptima rejects any disclaimer by CONTRACTOR of any warranty, standard, implied or express, unless specifically agreed to in writing by both parties.

13.5 Any CalOptima property damaged by CONTRACTOR, its subcontractor(s), or by the personnel of either, will be subject to repair and replacement by CONTRACTOR at no cost to CalOptima.

14. Compensation.

14.1 Payment.

14.1.1 CalOptima agrees to pay, and CONTRACTOR agrees to accept as full consideration for the faithful performance of this Contract, the rates, charges and other payment terms identified in Exhibit B, which is attached hereto and incorporated herein by this reference.

14.1.2 CalOptima will not reimburse CONTRACTOR any expenses incurred in connection with its performance of the services, unless such reimbursement is specifically authorized in Exhibit B. Each expense reimbursement request, when authorized in Exhibit B must include receipts or other suitable documentation.

14.1.3 CONTRACTOR's requests for payments and reimbursements must comply with the requirements set forth in Exhibit B. CalOptima will not make payment for work that fails to meet the standards of performance as set forth in the Contract and Exhibit A, Scope of Work that may be reasonably expected by CalOptima. **CALOPTIMA SHALL NOT PAY ANY FEES, EXPENSES OR COSTS WHATSOEVER INCURRED BY CONTRACTOR IN RENDERING ADDITIONAL SERVICES NOT AUTHORIZED IN WRITING UNDER THIS CONTRACT.**

14.1.4 In no event shall the total compensation payable to CONTRACTOR for the services performed under this Contract exceed the maximum cumulative payment obligation, as set forth in the attached Exhibit B, without the express prior written authorization of CalOptima. CONTRACTOR shall at all times monitor its costs and expenditures for work performed under this Contract, and shall monitor its invoices, costs, and expenditures, to ensure it does not exceed the maximum cumulative payment obligation set forth herein. CONTRACTOR shall provide CalOptima with 60 days written notice if at any time during this Contract CONTRACTOR becomes aware that it may exceed the maximum cumulative payment obligation authorized under this Contract. **CONTRACTOR ACKNOWLEDGES AND AGREES THAT CALOPTIMA SHALL NOT BE LIABLE FOR ANY FEES, EXPENSES OR COMPENSATION IN EXCESS OF THE MAXIMUM CUMULATIVE PAYMENT OBLIGATION.**

14.1.5 The maximum cumulative payment obligation includes all applicable federal, state, and local taxes and duties, except sales tax, which is shown separately, if applicable. CONTRACTOR is responsible for submitting any withholding exemption forms (e.g., W-9) to CalOptima. Such forms and information should be furnished to CalOptima before payment is made. If taxes are required to be withheld on any amounts otherwise to be paid by CalOptima to CONTRACTOR due to CONTRACTOR'S failure to timely

submit such forms, CalOptima will deduct such taxes from the amount otherwise owed and pay them to the appropriate taxing authority, and shall have no liability for or any obligation to refund any payments withheld.

14.2 Contractor Travel Policy. CONTRACTOR agrees to abide by the terms of the CalOptima Travel Policy, attached hereto as Exhibit C, and incorporated herein by this reference.

15. Term. This Contract shall commence on the date last signed below, and shall continue in full force and effect through 03/03/2025, ("Initial Term"), unless earlier terminated as provided in this Contract. At the end of the Initial Term, CalOptima may, at its option, extend this Contract for up to Two (2) additional consecutive one (1) year terms ("Extended Terms"), provided that if CalOptima does not exercise its option to extend at the end of the Initial Term, or any Extended Term, the remaining option(s) shall automatically lapse. As used in this Contract, the word "Term" shall include the Initial Term and any and all Extended Term(s), to the extent CalOptima exercises its option pursuant to this paragraph.

16. Termination.

16.1 Termination without Cause. CalOptima may terminate this Contract at any time, in whole or in part, for its convenience and without cause, by giving CONTRACTOR thirty (30) days written notice hereof. Upon termination, CalOptima may pay CONTRACTOR its allowable cost incurred for services satisfactorily performed and accepted by CalOptima as of the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima under this Contract.

16.2 Termination for Unavailability of Funds. In recognition that CalOptima is a governmental entity and its operations and budgets are determined on an annual basis, CalOptima shall have the right to terminate this Contract as follows:

16.2.1 CalOptima may terminate this Contract if it does not receive funding from the State of California or the federal government, as applicable, for any fiscal year.

16.2.2 In the event of Termination for Unavailability of Funds, as provided in this Section, CalOptima agrees to promptly pay CONTRACTOR all fees and other charges due and payable for services satisfactorily performed and accepted by CalOptima as of the termination date. CONTRACTOR shall not be entitled to payment for any other items, including, without limitation, lost or anticipated profit on work not performed, administrative costs, attorneys' fees, or consultants' fees.

16.2.3 In the event of Termination for Unavailability of Funds, as provided in this Section, and funds are received by CalOptima from the State of California within one-hundred twenty (120) days of the date of termination, then CalOptima shall promptly notify CONTRACTOR in writing and CalOptima shall have the right to reinstate this Contract for that period for which funds are received by CalOptima or the unexpired term of this Contract as of the date of termination, whichever period is shorter in duration. Notwithstanding the foregoing, CalOptima may only reinstate this Contract two (2) times during the Term of this Contract.

16.3 Termination for Default. Subject to a ten (10) day cure period, CalOptima may terminate this Contract for CONTRACTOR's default, or if a federal or state proceeding for the relief of debtors is undertaken by or against CONTRACTOR, or if CONTRACTOR makes an assignment for the benefit of creditors as defined in Section 6, or if CONTRACTOR breaches any term(s) or violates any provision(s) of this Contract and does not cure such breach or violation within ten (10) days after written notice thereof by CalOptima. In the event of Termination for Default, as provided by this Section, CONTRACTOR shall be liable for any and all reasonable costs incurred by CalOptima as a result of such default, including, but not limited to, reprocurement costs of the same or similar services defaulted by CONTRACTOR under this Contract.

16.4 Notwithstanding the foregoing, CalOptima may terminate this Contract immediately upon CONTRACTOR's breach of Section 3, (Insurance), Section 10, (Prohibited Interest), or Section 24, (Confidentiality).

16.5 Effect of Termination. Upon expiration or receipt of a termination notice under this Section:

16.5.1 CONTRACTOR shall promptly discontinue all services (unless the notice directs otherwise), and deliver or otherwise make available to CALOPTIMA all documents, reports, software programs and any other products, data and such other materials, equipment, and information, including but not limited to confidential information, or equipment provided by CalOptima, as may have been accumulated by CONTRACTOR in performing this Contract, whether completed or in process. If CONTRACTOR personnel were granted access to CalOptima's premises and issued a badge or access card, such badge or access card shall be returned prior to departure. Failure to return any information or equipment, badge or access card, is considered a material breach of this Contract and CalOptima's privacy and security rules.

16.5.2 CalOptima may take over the services, and may award another party a contract to complete the services under this Contract.

16.5.3 CalOptima may withhold from payment any sum that it determines to be owed to CalOptima by CONTRACTOR, or as necessary to protect CalOptima against loss due to outstanding liens or claims of former lien holders.

17. Modifications. CalOptima reserves the right to modify the Contract at any time should such modification be required by CMS or applicable law or regulation. Modifications shall be executed only by a written amendment to the Contract, signed by CalOptima and CONTRACTOR. Execution of amendments shall be contingent upon CONTRACTOR's notification to CalOptima, and CalOptima's approval, of any increase or decrease in the price of this Contract or in the time required for its performance.

18. Verification of CalOptima Costs by Government. Until the expiration of ten (10) years after the later of furnishing of any service pursuant to this Contract or completion of any audit, or longer as required by applicable regulations, CONTRACTOR will make available, upon written request of the Secretary of Health and Human Services or the Comptroller General of the United States or any of their duly authorized representatives, or the California Department of Health Care Services, or the California Department of Managed Health Care, or the Department of Justice, or the Bureau of Medical Fraud, copies of this Contract any information regarding its and any financial statements, books, documents, records, patient care documentation, and other records or data of CONTRACTOR that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Contract, or as are otherwise necessary to certify the nature and extent of costs incurred by CalOptima for such services. This provision shall also apply to any agreement between a subcontractor and an organization related to the subcontractor by control or common ownership. CONTRACTOR further agrees that regulating entities have the right to inspect, evaluate and audit any pertinent information and to facilitate the review of the items referenced herein, to make available its, records related to Medicare enrollees, and any additional relevant information that regulating entities may require. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

19. Confidential Material.

19.1 During the term of this Contract, either Party may have access to confidential material or information ("Confidential Information") belonging to the other Party or the other Party's customers, vendors, or partners. "Confidential Information" shall include without limitation the disclosing Party's computer programs and codes, business plans, customer/member lists and

information, financial records, partnership arrangements and licensing plans or other information, materials, records, writings or data that is marked confidential or that due to its character and nature, a reasonable person under like circumstances would treat as confidential. Confidential Information will be used only for the purposes of this Contract and related internal administrative purposes. Each Party agrees to protect the other's Confidential Information at all times and in the same manner as each protects the confidentiality of its own confidential materials, but in no event with less than a reasonable standard of care.

19.2 For the purposes of this Section 19, "Confidential Information" does not include information which: (i) is already known to the other Party at the time of disclosure; (ii) is or becomes publicly known through no wrongful act or failure of the receiving Party; (iii) is independently developed without use or benefit of the other's Confidential Information or proprietary information; (iv) is received from a third party which is not under and does not thereby breach an obligation of confidentiality; or (v) is a public record, not exempt from disclosure pursuant to California Public Records Act, Government Code Section 6250 et seq., applicable provisions of California Welfare and Institutions Code or other state or federal laws, regardless of whether such information is marked as confidential or proprietary.

19.3 Disclosure of the Confidential Information will be restricted to the receiving Party's employees, consultants, suppliers or agents on a "need to know" basis in connection with the services performed under this Contract, who are bound by confidentiality obligations no less stringent than these prior to any disclosure. The receiving Party may disclose Confidential Information pursuant to legal, judicial, or administrative proceeding or otherwise as required by law; providing that the receiving Party shall give reasonable prior notice, if not prohibited by applicable law, to the disclosing Party and shall assist the disclosing Party, at the disclosing Party's expense, to obtain protective or other appropriate confidentiality orders, and further provided that a required disclosure of Confidential Information or proprietary information to an agency or Court does not relieve the receiving Party of its confidentiality obligations with respect to any other party.

19.4 Except as to the confidentiality of trade secrets, these confidentiality restrictions and obligations will terminate five (5) years after the expiration or termination of the Contract, unless the law requires a longer period. Upon written request of the disclosing Party, the receiving Party shall promptly return to the disclosing Party all documents, notes and other tangible materials representing the disclosing Party's Confidential Information or Proprietary Information and all copies thereof. This obligation to return materials or copies thereof does not extend to automatically generated computer backup or archival copies generated in the ordinary course of the receiving Party's information systems procedures, provided that the receiving Party shall make no further use of such copies. Notwithstanding the foregoing or anything to the contrary in this Contract, each party shall be permitted to retain Confidential Information to the extent incorporated into its working papers and it shall maintain the confidentiality of such information in accordance with this contract.

19.5 For the purposes of this Section only, "Confidential Information" does not include protected health information or individually identifiable information, as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and other privacy statutes or regulations. The access, use and disclosure of Protected Health Information is referenced below in Section 24, and shall be governed by a Business Associate Protected Health Information Disclosure Agreement, which shall be executed by the parties if CONTRACTOR will create, receive, maintain, use, or transmit Protected Health Information in performing services under this Contract.

20. Record Ownership and Retention.

20.1 The originals of all final deliverables (which may be: documents, reports, software programs and any other products and data prepared or generated for the purposes of this Contract and delivered to CalOptima, excluding any CONTRACTOR Material (defined below) contained or embodied

therein (hereafter, "Works") shall become the property of CalOptima at no cost to CalOptima and in a form accessible for CalOptima's use. Copies of Works may be made for CONTRACTOR's records, but shall not be furnished to others without written authorization from CalOptima. Such Works shall become the sole property of CalOptima and all rights in copyright therein shall be retained by CalOptima subject to any restriction set forth in this Contract.. CalOptima's ownership of these documents includes use of, reproduction or reuse of such Works. CONTRACTOR shall provide all Works within a reasonable amount of time upon CalOptima's request, but in no event shall such time exceed thirty (30) calendar days unless otherwise specified by CalOptima. CONTRACTOR shall own its working papers and any engagement documentation and consulting-related general skills, know-how, expertise, ideas, concepts, methods, techniques, processes, software, materials or other intellectual property or information which may have been discovered, created, received, developed or derived by CONTRACTOR either prior to or as a result of providing services under this Contract ("CONTRACTOR Material"). CalOptima shall have a non-exclusive, non-transferable license to use CONTRACTOR Material in accordance with this Contract to the extent that they form part of the Works. Notwithstanding anything to the contrary in this Contract, CONTRACTOR and its personnel are free to use and employ their general skills, know-how, and expertise, and to use, disclose, and employ any generalized ideas, concepts, know-how, methods, techniques, or skills gained or learned during the course of this Contract so long as they acquire and apply such information without any unauthorized use or disclosure of confidential or proprietary information of CalOptima.

20.2 CONTRACTOR hereby assigns to CalOptima all of its rights in all Works prepared by or on behalf of CalOptima under this Contract ("Works"), and this Contract shall be deemed a transfer to CalOptima of the sole and exclusive copyright of any copyrightable subject matter CONTRACTOR created in these Works. CONTRACTOR agrees to cause its agents and employees to execute any documents necessary to secure or perfect CalOptima's legal rights and worldwide ownership in such materials, including, but not limited to, documents relating to patent, trademark and copyright applications. Upon CalOptima's request, CONTRACTOR will return or transfer all Works, in CONTRACTOR's possession or control belonging to CalOptima.

20.3 Notwithstanding the foregoing, CONTRACTOR's intellectual property ("CONTRACTOR IP") that preexists this Contract shall remain the sole and exclusive property of CONTRACTOR. CONTRACTOR shall not incorporate any CONTRACTOR IP into the Works that would limit CalOptima's use of the Works without CalOptima's written approval. To the extent that CONTRACTOR incorporates any CONTRACTOR IP into the Works, CONTRACTOR hereby grants to CalOptima a non-exclusive, irrevocable, perpetual, worldwide, royalty-free license to use and reproduce the CONTRACTOR IP to the extent required to fully utilize the Works.

20.4 CONTRACTOR acknowledges and agrees that, notwithstanding any provision herein to the contrary, CalOptima's Intellectual Property ("CalOptima IP") in the information, documents and other materials provided to CONTRACTOR shall remain the sole and exclusive property of CalOptima. Any information, documents or materials provided by CalOptima to CONTRACTOR pursuant to this Contract and all copies thereof (including without limitation CalOptima IP, Proprietary Information and Confidential Information, as these terms are defined in Section 19) shall upon the earlier of CalOptima's request or the expiration or termination of this Contract be returned to CalOptima.

20.5 For purposes of this Section, Intellectual Property shall mean patents, copyrights, trademarks, trade secrets, and other proprietary information.

21. Patent and Copyright Infringement. In lieu of any other warranty by CalOptima or CONTRACTOR against infringement, statutory or otherwise, it is agreed that CONTRACTOR shall indemnify, hold harmless and defend, at its expense, any suit against CalOptima based on a claim that Works, or the normal use or sale thereof, infringes on any United States letters patent, patent, trademark, copyright, or other intellectual property right, and shall pay costs and damages finally awarded in any such suit, provided that

CONTRACTOR is notified in writing of the suit and given authority, information, and assistance at CONTRACTOR's expense for the defense of the suit. CONTRACTOR, at no expense to CalOptima, shall obtain for CalOptima the right to use and sell said item, or shall substitute an equivalent item acceptable to CalOptima and extend this patent indemnity thereto.

22. Names and Marks. Neither Party shall use the name, logo or other proprietary mark of the other in any press release, advertising, promotional, marketing or similar publicly disseminated material without first submitting such material to the other Party and obtaining the other Party's express written approval of the material and consent to such use.

23. Business Associate Protected Health Information Disclosure Agreement. CONTRACTOR agrees to incorporate the Business Associate Protected Health Information Disclosure Agreement with CalOptima signed on 6/16/2015, if CONTRACTOR will create, receive, maintain, use, or transmit PHI/PHI, which agreement shall be incorporated herein by this reference. CONTRACTOR acknowledges and agrees that CalOptima reserves the right to modify the Business Associate Protected Health Information Disclosure Agreement at any time should such modification be required by applicable law or regulation.

24. Confidentiality of Member Information.

24.1 CONTRACTOR and its employees, agents, or subcontractors shall protect from unauthorized disclosure, the names and other identifying information concerning persons either receiving services through CalOptima ("Member") or persons, including Members, pursuant to this Contract, or persons whose names or identifying information become available or are disclosed to CONTRACTOR, its employees, agents, or subcontractors as a result of services performed under this Contract, except for statistical information not identifying any such person. CONTRACTOR and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out CONTRACTOR's obligations under this Contract. CONTRACTOR and its employees, agents, or subcontractors shall promptly transmit to CalOptima all requests for disclosure of such identifying information not emanating from the Member. CONTRACTOR shall not disclose, except as otherwise specifically permitted by this Contract or authorized by the Member, any such identifying information to anyone other than DHCS or CalOptima without prior written authorization from CalOptima. 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.

24.2 Names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42 CFR Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by CONTRACTOR from unauthorized disclosure. CONTRACTOR may release Medical Records in accordance with applicable law pertaining to the release of this type of information. CONTRACTOR is not required to report requests for Medical Records made in accordance with applicable law. With respect to any identifiable information concerning a Member under this Contract that is obtained by CONTRACTOR or its Subcontractors, CONTRACTOR:

24.2.1 Will not use any such information for any purpose other than carrying out the express terms of this Contract;

24.2.2 Will promptly transmit to CalOptima all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law;

24.2.3 Will not disclose, except as otherwise specifically permitted by this Contract, any such information to any party other than DHCS or CalOptima without CalOptima's prior written authorization specifying that the information is releasable under Title 42 CFR

Section 431.300 et seq., Section 14100.2, Welfare and Institutions Code, and regulations adopted there under; and

24.2.4 Will, at the termination of this Contract, return all such information to CalOptima or maintain such information according to written procedures sent to the CONTRACTOR by CalOptima for this purpose.

24.3 CONTRACTOR agrees to complete a CalOptima Medi-Cal Data Access Agreement, which is attached hereto as Exhibit D and incorporated herein by this reference. All materials covered under this Medi-Cal Data Access Agreement shall be designated confidential, to the extent permitted by California law.

25. Offshore Performance.

25.1 Due to security and identity protection concerns, direct services under this Contract shall not be performed by offshore subcontractors, unless otherwise authorized in writing by CalOptima.

25.2 CONTRACTOR shall complete, sign, and return Exhibit H, entitled "Attestation Concerning the Use of Offshore Subcontractors," which is attached hereto and incorporated herein by this reference, and shall submit an executed Offshore Subcontractor Attestation no less than annually thereafter.

25.3 CONTRACTOR acknowledges that CalOptima requires CONTRACTOR to obtain approval from it of CONTRACTOR's use of any offshore subcontractor whereby offshore subcontractor will have access to any type of confidential CalOptima Member information, including, but not limited to, protected health information. CONTRACTOR represents and warrants that it has disclosed to CalOptima any and all such offshore subcontractors within Exhibit H and that it has obtained CalOptima's written approval to use such offshore subcontractors prior to the effective date of this Contract.

25.4 Any new subcontract with an offshore entity under which the offshore entity will have access to any confidential CalOptima Member or other protected health information must be approved in writing by CalOptima prior to execution of the subcontract. CONTRACTOR is required to submit future Offshore Contractor Attestations to CalOptima's Purchasing Department within thirty (30) calendar days after it has signed a contract with any subcontractor that may be using an offshore subcontractor to perform any related work.

25.5 Unless specifically stated otherwise in this Contract, the restrictions of this Section do not apply to indirect or "overhead" services, or services that are incidental to the performance of the Contract.

25.6 The provisions of this Section apply to work performed by subcontractors at all tiers.

26. Medicare Advantage Program. CONTRACTOR agrees to abide by the terms of "Addendum 1, Medicare Advantage Program," attached hereto as Exhibit G and incorporated herein by this reference.

27. Time is of the Essence. Time is of the essence in performance of this Contract.

28. CalOptima Designee. The Chief Executive Officer of CalOptima, or his designee, shall have the authority to act for and exercise any of the rights of CalOptima, as set forth in this Contract, subsequent to and in accordance with the authority granted by the Board of Directors.

29. Omissions. In the event that either party hereto discovers any material omission in the provisions of this Contract which such party believes is essential to the successful performance of this Contract, the party may so inform the other party in writing, and the parties hereto shall thereafter promptly negotiate in good

faith with respect to such matters for the purpose of making such reasonable adjustments, as may be necessary to perform the objectives of this Contract.

30. Choice of Law. This Contract shall be governed by and construed in accordance with all laws of the State of California. In the event any party institutes legal proceedings to enforce or interpret this Contract, venue and jurisdiction shall be in the County of Orange, California.

31. Force Majeure. When satisfactory evidence of a cause beyond a party's control is presented to the other party, and nonperformance is unforeseeable, beyond the control, and not due to the fault of the party not performing, a party shall be excused from performing its obligations under this Contract during the time and to the extent that it is prevented from performing by such cause, including, but not limited to, any incidence of fire, flood, acts of God, commandeering of material, products, plants or facilities by the federal, state or local government, or a material act or omission by the other party.

32. Notices. All notices required or permitted under this Contract and all communications regarding the interpretation of the terms of this Contract, or changes thereto, shall be in writing and shall be sent by registered or certified mail, postage prepaid, return receipt requested, or by any other overnight delivery service which delivers to the noticed destination and provides proof of delivery to the sender. All notices shall be effective when first received at the following addresses set forth below. Any party whose address changes shall notify the other party in writing.

To CONTRACTOR:	To CalOptima:
Moss Adams LLP	CalOptima
2040 Main Street, Suite 900	505 City Parkway West
Irvine, CA 92614	Orange, CA 92868
Attention: Aparna Venkateswaran	Attention: Ryan Prest

33. Notice of Labor Disputes. Whenever CONTRACTOR has knowledge that any actual or potential labor dispute may delay this Contract, CONTRACTOR shall immediately notify and submit all relevant information to CalOptima. CONTRACTOR shall insert the substance of this entire clause in any subcontract hereunder as to which a labor dispute may delay this Contract.

34. Unavoidable Delays.

34.1 If the delivery of services under this Contract should be unavoidably delayed, CalOptima's Purchasing Department shall extend the time for completion of the Contract for the determined number of days of excusable delay. A delay is unavoidable only if the delay was not reasonably expected to occur in connection with, or during CONTRACTOR's performance, and was not caused directly or substantially by acts, omissions, negligence, or mistakes of CONTRACTOR, CONTRACTOR's subcontractors, or their agents, and was substantial and in fact caused CONTRACTOR to miss delivery dates, and could not adequately have been guarded against by contractual or legal means. Delays caused by CalOptima will be sufficient justification for delay of services, and CONTRACTOR shall be allowed a day-for-day extension.

34.2 CONTRACTOR shall notify CalOptima's Purchasing Department as soon as CONTRACTOR has, or should have, knowledge that an event has occurred that will delay deliveries. Within five (5) working days, CONTRACTOR shall confirm such notice in writing, furnishing as much detail as is available.

34.3 CONTRACTOR agrees to supply, as soon as such data is available, any reasonable proof that is required by CalOptima's Purchasing Department to make a decision on any request for extension. CalOptima's Purchasing Department shall examine the request and any documents supplied by CONTRACTOR and shall determine if CONTRACTOR is entitled to an extension and the duration of such extension. CalOptima's Purchasing Department shall notify CONTRACTOR of this decision in writing. It is expressly understood and agreed that CONTRACTOR shall not be entitled to damages or compensation, and shall not be reimbursed for losses on account of delays resulting from any cause under this provision.

35. No Liability of County of Orange. As required under Ordinance No. 3896 of the County of Orange, State of California, as amended, the parties hereto acknowledge and agree that the obligations of CalOptima under this Contract are solely the obligations of CalOptima, and the County of Orange, State of California, shall have no obligation or liability therefor.

36. Entire Agreement. This Contract, including all exhibits and documents incorporated by reference and all Contract Documents referenced in Section 1 herein, contains the entire agreement between CONTRACTOR and CalOptima with respect to the subject matter of this Contract, and it supersedes all prior written or oral and all or contemporaneous oral agreements, representations, understandings, discussions, negotiations and commitments between CONTRACTOR and CalOptima, whether express or implied, with respect to the subject matter of this Contract.

37. Headings. The section headings used herein are for reference and convenience only and shall not enter into the interpretation hereof.

38. Waiver. No delay or failure by either party hereto to exercise any right or power accruing upon noncompliance or default by the other party with respect to any of the terms of this Contract shall impair such right or power, or be construed to be a waiver thereof. A waiver by either of the parties hereto of a breach of any of the covenants, conditions or agreements to be performed by the other shall not be construed to be a waiver of any succeeding breach thereof, or of any other covenant, condition, or agreement herein contained. Any information delivered, exchanged, or otherwise provided hereunder shall be delivered, exchanged or otherwise provided in a manner that does not constitute a waiver of immunity or privilege under applicable law.

39. California Public Records Act. As a local public agency, CalOptima is subject to the California Public Records Act (California Government Code Sections 6250 et seq.) (the "Public Records Act"). CONTRACTOR hereby acknowledges that any materials, documents, data, or similar items are subject to disclosure upon public request, unless they are exempt from disclosure under the provisions of the Public Records Act. CalOptima may be required to reveal certain information believed to be proprietary or confidential by CONTRACTOR pursuant to the Public Records Act. In the event that CONTRACTOR discloses information that it believes to be proprietary or confidential to CalOptima, it shall mark such information as "Confidential," "Proprietary," or "Restricted" or other similar marking. Unless CONTRACTOR marks its materials as "Confidential," "Proprietary," or "Restricted," and also notifies CalOptima in writing that CONTRACTOR has so marked each piece of material, then CalOptima will not be responsible to take any actions to protect any CONTRACTOR's materials under the Public Records Act that are not so marked. In the event CalOptima receives a request under the Public Records Act that potentially encompasses CONTRACTOR materials that have been properly marked, CalOptima will provide CONTRACTOR with notice thereof to allow CONTRACTOR to take actions it deems appropriate to prevent disclosure of the marked material. CONTRACTOR agrees to defend, indemnify, and hold harmless CalOptima, its officers, agents, employees, members, subsidiaries, joint venture partners, and predecessors and successors in interest from and against any claim, action, proceeding, liability, loss, damage, cost, or expense, including, without limitation, attorneys' fees, and any costs awarded to the person or entity that sought the CONTRACTOR marked material, arising out of or related to CalOptima's failure to produce or provide the CONTRACTOR marked material (collectively referred to for purposes of this Section as "Public Records Act Claim(s)"). CONTRACTOR shall pay to CalOptima any expenses or charges relating to or arising from any such Public Record Act Claim(s) as they are incurred by CalOptima.

40. Audit Disclosure. Pursuant to California Government Code Section 8546.7, if this Contract is over ten thousand dollars ($10,000), it is subject to examination and audit of the State Auditor, at the request of CalOptima, or as part of any audit of CalOptima, for a period of three (3) years after final payment under this Contract. In addition to and notwithstanding any other right of access or inspection that may be otherwise set forth in this Contract or its attachments, CONTRACTOR agrees that, during the term of this Contract and for a period of three (3) years after its termination, CalOptima shall have access to and the right to examine any directly pertinent books, documents, invoices, and records of CONTRACTOR relating to services provided under this Contract. Where another right of access or inspection in this Contract provides for a period of greater than three (3) years, nothing herein shall be construed to shorten that time period. The foregoing shall not include access to: (i) working papers by the audited entity as such access could impair the effectiveness of the audit work plan; or (ii) to books, records, documents, or facilities containing confidential information of other clients for whom CONTRACTOR provides services, or CONTRACTOR'S proprietary data.

41. Debarment and Suspension Certification.

41.1 By signing this Contract, the CONTRACTOR agrees to comply with any and all applicable Federal suspension and debarment regulations.

41.2 By signing this Contract, the CONTRACTOR certifies to the best of its knowledge and belief, that it and its principals:

41.2.1 Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

41.2.2 Have not within a three-year period preceding this Contract 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;

41.2.3 Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph 42.2.2 herein;

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

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

41.2.6 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.

41.3 If the CONTRACTOR is unable to certify to any of the statements in this certification, the CONTRACTOR shall submit an explanation to CalOptima.

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

41.5 If the CONTRACTOR knowingly violates this certification, in addition to other remedies available to the Federal Government, CalOptima may terminate this Contract for cause or default.

42. Lobbying Restrictions and Disclosure Certification.

42.1 Applicable to federally funded contracts in excess of $100,000 per Section 1352 of the 31, U.S.C.

42.2 Certification and Disclosure Requirements.

42.2.1 Each person (or recipient) who requests or receives a contract, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Exhibit E, Part 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph 43.3of this provision. Exhibit E is attached hereto and incorporated herein by this reference.

42.2.2 Each recipient shall file a disclosure (in the form set forth in Exhibit E, Part 2, entitled "Certification Regarding Lobbying") if such recipient has made or has agreed to make any payment using nonappropriated 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 43.3 of this provision if paid for with appropriated funds.

42.2.3 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 43.2.2herein. An event that materially affects the accuracy of the information reported includes:

42.2.3.1 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;

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

42.2.3.3 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.

42.2.3.4 Each person (or recipient) who requests or receives from a person referred to in Paragraph 43.2.1of this provision a contract, subcontract, grant or subgrant 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.

42.2.3.5 All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph 43.2.1of this provision. That person shall forward all disclosure forms to CalOptima Purchasing Manager.

42.3 Prohibition—Section 1352 of Title 31, U.S.C., 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.

43. Air and Water Pollution Requirements. Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR § 15.5. CONTRACTOR agrees 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.

44. Survival. The following provisions of this Contract shall survive termination or expiration of this Contract: Prohibited Interest, Warranties, Compensation, Confidentiality, Indemnification, Duty to Defend, Ownership of Records and Documents, Record Retention, Audit Disclosure, California Public Records Act, Patent and Copyright Infringement, Governing Law, and this Section.

45. Severability. If any section, subsection or provision of this Contract, or any Contract Documents incorporated into this Contract, or the application of such section, subsection or provision, is held invalid or unenforceable by any court of competent jurisdiction, the remainder of this Contract, other than that to which it is held invalid, shall not be affected thereby.

46. Third Party Beneficiaries. There are no intended third party beneficiaries of this Contract. Nothing in this Contract shall be construed as conferring any rights on any other persons. CalOptima and CONTRACTOR are the only parties to this contract and are the only parties entitled to enforce its terms. Nothing in this contract gives, is intended to give, or shall be construed to give or provide any benefit or right, whether directly, indirectly or otherwise, to third persons.

47. Successors and Assigns. Except as otherwise expressly provided in this Contract, this Contract will be binding on, and will inure to the benefit of, the successors and permitted assigns of the Parties to this Contract. Nothing in this Contract is intended to confer upon any Party other than the Parties hereto or their respective successors and permitted assigns any rights or obligations under or by reason of this Contract, except as expressly provided in this Contract.

48. Authority to Execute. The persons executing this Contract on behalf of the Parties warrant that they are duly authorized to execute this Contract and that by executing this Contract the Parties are formally bound.

49. Counterparts. This Contract may be executed and delivered in one or more counterparts, each of which shall be deemed an original, but all of which together will constitute one and the same instrument.

50. Limitation of Liability. IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES IN CONNECTION WITH OR OTHERWISE ARISING OUT OF THIS AGREEMENT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT. NOTWITHSTANDING THE FOREGOING, THIS SECTION DOES NOT APPLY TO FRAUD OR WILLFUL MISCONDUCT.

[Remainder of page left intentionally blank. Signatures on following page]

IN WITNESS WHEREOF, these Parties have, by their duly authorized representatives, executed this Contract No. 22-10461 on the day and year last shown below.

MOSS ADAMS LLP	CalOptima
By: Stacy J. Stelzriede	By:
Print Name: Stacy J. Stelzriede	Print Name:
Title: Partner	Title:
Date: 2/16/2022	Date:

By:	By:
Print Name:	Print Name:
Title:	Title:
Date:	Date:

If CONTRACTOR is a corporation, two officer signatures or a Corporation Resolution or Corporate Seal is required

Exhibit A

SCOPE OF WORK

A. NATURE OF SERVICS REQUIRED

1. General

   CONTRACTOR shall provide Financial Auditing Services beginning with the fiscal year ending June 30, 2022 for CalOptima and Single Audit for CalOptima's Multipurpose Senior Services Program (MSSP). CONTRACTOR will be expected to enable CalOptima to comply with the Single Audit requirements of the Office of Management and Budget (OMB) *Compliance Supplement*. The audit shall be performed in accordance with generally accepted auditing standards in the United States of America and the standards for financial audits contained in Government Auditing Standards, issued by the Comptroller General of the United States.

2. Objective

   CONTRACTOR shall express an opinion on the fair presentation of CalOptima's financial statements, taken as a whole, in conformity with accounting principles generally accepted in the United States of America.

3. Scope of Work

   The following sections provide additional detail and describe the specific areas to be audited.

   a. The CONTRACTOR shall conduct an audit of the financial statements of CalOptima in accordance with the auditing standards generally accepted in the United States of America and therefore shall conduct such tests of the accounting records and such other auditing procedures considered necessary under the circumstances in order for the CONTRACTOR to render an opinion of the financial statements of CalOptima for the fiscal year ending June 30.

   b. The CONTRACTOR shall conduct a Single Audit in accordance with the OMB Compliance Supplement. The CONTRACTOR shall, in conjunction with the audit of CalOptima's financial statements, conduct audits described in the following three (3) paragraphs and issue a separate report thereon:

      i. the audit shall be the financial and compliance type described in the *Standards for Audit of Government Organizations, Programs, Activities and Functions* published by the Comptroller General of the United States;

      ii. the CONTRACTOR's examination of CalOptima's financial statements shall be the financial type described in the American Institute of Certified Public Accountants (AICPA) Industry Audit Guide, Audits of State and Local Government Units and the Governmental Accounting and Financial Reporting Standards published by the Governmental Accounting Standards Board. The examination shall be conducted in accordance with auditing standards generally accepted in the United States of America leading to expression of an opinion in compliance with Rule 58.1 of the California State Board of Accountancy; and

      iii. the compliance examination shall enable the CONTRACTOR to determine whether the organization has complied with the laws and regulations that may have material effect of each major Federal assistance program. The CONTRACTOR shall supply special reports and expressions as required by the cognizant agency and express an opinion on CalOptima's compliance with all Federal assistance programs in accordance with OMB Compliance Supplement.

c. Other areas that CONTRACTOR shall review include identifying and ensuring compliance to laws, regulations, contracts and grants applicable to CalOptima by performing tests of CalOptima's compliance with certain provisions of laws, regulations, contracts and grants, including if CalOptima is complying with the uniform accounting standards and procedures as specified by the State of California Administrative code.

d. The CONTRACTOR shall also assess the accounting principles used and significant estimates made by management, as well as evaluate the overall financial statement presentation. The CONTRACTOR should be available and responsive throughout the year to offer guidance on accounting treatment or presentation questions that may come up surrounding new and significant transactions or events. In addition, they should advise CalOptima on any new accounting principle or change requirements prior to year end.

e. The audit shall be performed to obtain assurance about whether the financial statements are free of material misstatement, whether caused by error or fraud. The CONTRACTOR shall be required to inform CalOptima management about any material errors and any instances of fraud or illegal acts. Further, the CONTRACTOR shall inform CalOptima's Board of Directors about fraud and illegal acts that involve senior management, fraud that in CalOptima's judgment causes a material misstatement of the financial statements of CalOptima, and illegal acts, unless clearly inconsequential, that have not otherwise been communicated to the Board of Directors.

f. In planning and performing the audit, the CONTRACTOR shall consider CalOptima's internal control in order to determine the nature, timing and extent of the auditing procedures for the purpose of expressing an opinion on the financial statements and not to provide assurance on internal control. This consideration should contribute to the evidence supporting the CONTRACTOR's opinion on the financial statements.

4. Auditing Standards to be Followed

The audit shall be performed in accordance with generally accepted auditing standards as set forth by the American Institute of Certified Public Accountants, the standards for financial audits set forth in the U.S. General Accounting Office's *Government Auditing Standards* (1994), the provisions of the Single Audit Act of 1984 (as amended in 1996) and the provisions of the U.S. Office of Management and Budget (OMB) *Compliance Supplement.*

5. Reports to be Issued

Following the completion of the audit of each fiscal year's financial statement, the CONTRACTOR shall issue to the CalOptima Board of Directors and CalOptima management the following:

a. two reports on the fair presentation of the financial statements in conformity with the accounting principles generally accepted in the United States of America:
   i. one with Government Auditing Standards (GAS) references
   ii. one without Government Auditing Standards references (Non-GAS)

b. a report on compliance and internal control over financial reporting based on an audit of the financial statements. Such information shall include a management letter on internal controls within the reporting deadlines as required by the State of California Department of HealthCare Services, Department of Managed Health Care and Department of Aging. The CONTRACTOR shall also be expected to address the CalOptima Board of Directors with their findings; and

c. in the required reports on compliance and internal controls, the CONTRACTORs shall communicate any reportable conditions found during the audit. A reportable condition shall be defined as a significant deficiency in the design or operation of the internal control structure,

which could adversely affect the organization's ability to record, process, summarize and report financial data consistent with the assertations of management in the financial statements. Reportable conditions that are also material weaknesses shall be identified as such in the report. Non-reportable conditions discovered by the CONTRACTOR shall be reported in a separate letter to management, which shall be referred to in the reports on compliance and internal controls. The reports on compliance and internal controls shall include all instances of noncompliance.

d. CONTRACTOR shall be required to make an immediate, written report to CalOptima of any and all irregularities and illegal acts, or indications of illegal acts, of which they become aware while auditing CalOptima.

e. Information Required. CONTRACTOR shall assure themselves that CalOptima is informed of each of the following:
   i. the CONTRACTOR's responsibility under generally accepted auditing standards;
   ii. significant accounting policies;
   iii. management judgments and accounting estimates;
   iv. significant audit adjustments;
   v. other information in documents containing audited financial statements;
   vi. disagreements with management;
   vii. management consultation with other accountants;
   viii. major issues discussed with management prior to retention; and
   ix. difficulties encountered in performing the audit

6. OMB Compliance Supplement

   a. As required by the OMB Compliance Supplement, CONTRACTOR shall prepare a written report which:
      i. will provide the CONTRACTOR's opinion on the schedule of expenditures of federal awards in relation to CalOptima;
      ii. will provide the CONTRACTOR's opinion on compliance with laws, regulations, contracts, and grants that could have a direct and material effect on a major federal program; and
      iii. will communicate CONTRACTOR's consideration of internal control over major federal programs.

   b. The CONTRACTOR may be required to assist CalOptima with the preparation of the following:
      i. schedule of expenditures of federal awards;
      ii. summary schedule of prior audit findings; and
      iii. data collection form (Part 1)

   c. Certain provisions of OMB Compliance Supplement allow a granting agency to request that a specific program be selected as a major program provided that the federal granting agency is willing to pay the incremental audit cost arising from such selection. CalOptima will agree to notify the CONTRACTOR of any such request by a granting agency and to work with CONTRACTOR to modify the terms of the agreement as necessary to accommodate such a request.

7. Working Paper Retention and Access to Working Papers

   All working papers and reports shall be retained, at the CONTRACTOR's expense, for a minimum of seven (7) years following the conclusion of each fiscal year's audit, unless the firm is notified in writing by CalOptima of the need to extend the retention period. Upon written request, the CONTRACTOR shall be required to make working papers available to State of California Department of HealthCare Services, Department of Managed Health Care and Department of Aging. In addition, the firm shall respond to the reasonable inquiries of successor CONTRACTORs and allow successor CONTRACTORs to review working papers related to matters of continuing accounting significance.

8. Additional Engagement Issues

All reports submitted by CONTRACTOR on internal control and on compliance with laws, regulations, contracts and grants shall indicate that they are intended solely for the information and use of the audit committee (or its equivalent) and management of CalOptima and federal awarding agencies and pass-through entities and are not intended to be and should not be used by anyone other than these specified parties.

B. DESCRIPTION OF CALOPTIMA

1. General Financial Information about CalOptima

CalOptima management is responsible for establishing and maintaining an internal control structure designed to ensure that the assets of CalOptima are protected from loss, theft or misuse, and that accounting data are compiled to allow for preparation of the financial statements in conformity with accounting principles generally accepted in the United States of America. The internal control structure is designed to provide reasonable, but not absolute, assurance that these objectives are met. The concept of reasonable assurance recognizes that: (1) the cost of a control should not exceed the benefits likely to be derived; and (2) the evaluation of costs and benefits requires estimates and judgments by management.

CalOptima maintains an automated accounting system and prepares monthly financial reports covering the entirety of the financial operations of CalOptima. The automated accounting system utilized is Great Plains. This system is a client/server on-line processing system. The system runs on an SQL server housed at the CalOptima administrative office facilities. CalOptima's financial statements have been audited annually by independent Certified Public Accountants.

CalOptima's staff includes an actuarial team that is part of Financial Analysis that prepares the monthly IBNR for recording. Annually, CalOptima contracts with an outside actuary to independently review IBNR and make recommendations.

CalOptima currently contracts with Grant Thornton for internal auditing. The reports when available are presented to the Finance and Audit Committee. Internal Audit reports will be made available to the contracted independent CONTRACTOR.

C. TIME REQUIREMENTS

1. Schedule for the 2022 and Succeeding Fiscal Year Audits of the Financial Statements

Each of the following shall be completed by the CONTRACTOR no later than the dates indicated. Should CalOptima require additional time, up to 40 days, the CONTRACTOR shall ensure that all necessary CONTRACTOR resources remain available to complete the audit as close to the scheduled dates as possible.

Task	Completion Date
The CONTRACTOR shall provide CalOptima with a detailed annual audit plan to include a list of all schedules to be prepared by CalOptima	March 31
All annual interim work shall be completed by the CONTRACTOR	May 31
All year-end annual field work shall be completed by CONTRACTOR	3rd week of August

All management final draft reports and recommendations shall be available for review by CalOptima's CFO and Executive Management	August 31
The CONTRACTOR shall make their presentation to CalOptima's Board of Directors Finance and Audit Committee at the September Meeting.	Third Thursday in September
The Final Report with fifteen (15) signed copies delivered to CalOptima	September 30
The CONTRACTOR shall make their presentation to CalOptima's Board of Directors at the October Meeting.	First Thursday in October

2. Entrance Conferences, Progress Reporting and Exit Conferences

At a minimum, the following conferences shall be conducted by dates indicated below:

Meeting Description	Completion Date
Entrance Conference with CFO, Controller, and key Fiscal Services department staff	(to be determined – prior to interim)
Progress Conferences	Weekly during interim audit and weekly from start of audit through final report delivery
Exit conference with CFO and Fiscal Services management staff	Last business day or field audit day in August

3. CalOptima's CFO, Controller, Fiscal Services department staff, and responsible management personnel will be available during the audit to assist the CONTRACTOR by providing information, documentation, and explanations. Interim audit fieldwork should be planned and conducted during the last two weeks of any given month so as not to interfere with month-end close activities.
   a. CalOptima will provide the CONTRACTOR with reasonable work space, desks, and chairs. The CONTRACTOR will also be provided with access to one (1) telephone line, internet access, photocopying facilities and FAX machines.

   b. The preparation of confirmations shall be the responsibility of CalOptima under the direction of the CONTRACTOR

   c. Report preparation, editing and printing shall be the responsibility of the CONTRACTOR with input and review by CalOptima.

Exhibit B

PAYMENT

A. For CONTRACTOR's full and complete performance of its obligations under this Contract, CalOptima shall pay CONTRACTOR for fees and expenses in accordance with the provisions of this Exhibit and subject to the maximum cumulative payment obligations specified below.

B. CONTRACTOR shall invoice CalOptima on a milestone basis per the fixed fee pricing. The rates, as defined below, are acknowledged to include CONTRACTOR's base labor rates, overhead and profit. Work completed shall be documented in a monthly progress report prepared by CONTRACTOR, which report shall accompany each invoice submitted by CONTRACTOR. CONTRACTOR shall also furnish such other information as may be requested by CalOptima to substantiate the validity of an invoice. At its sole discretion, CalOptima may decline to make full payment for any work and direct costs until such time as CONTRACTOR has documented, to CalOptima's satisfaction, that CONTRACTOR has fully completed all work required under this Contract and CONTRACTOR's performance is accepted by CalOptima. CalOptima's payment in full for any work shall not constitute CalOptima's final acceptance of CONTRACTOR's work under this Contract.

C. CONTRACTOR shall submit to CalOptima, to the attention of Accounts Payable, accountspayable@caloptima.org, an invoice at the conclusion of every month for the Services performed during the prior thirty (30) days. Each invoice shall cite Contract No. 22-10461; specify the number of hours worked; the specific dates the hours were worked; the description of work performed; the time period covered by the invoice and the amount of payment requested; and be accompanied by a progress report. CalOptima shall remit payment within thirty (30) days of receipt and approval of each invoice.

D. Notwithstanding any provisions of this Contract to the contrary, CalOptima and CONTRACTOR mutually agree that CalOptima's maximum cumulative payment obligation hereunder for work performed and/or products received on Exhibit A of this Contract shall not exceed Two Hundred Five Thousand Dollars ($205,000) including all amounts payable to CONTRACTOR for its direct labor and expenses, overhead costs, fixed fee, subcontracts, leases, materials, and costs arising from or due to termination of this Contract; provided, however, that if there is a substantial change in the volume of work required under this Contract, the parties will negotiate in good faith to adjust the fixed fee accordingly.

E. Not included in the maximum cumulative payment obligation above, CONTRACTOR shall also invoice CalOptima on a monthly basis for out-of-pocket expenses (including travel-related expenses), calculated at 5% of the fees in Section D. All travel-related expenses charged to CalOptima under this Contract shall be consistent with Exhibit C, CalOptima's Travel Policy. Receipts or reasonable evidence thereof are required for commercial travel, car rental, parking, lodging, and food. When CONTRACTOR personnel visit more than one client on the same trip, the expenses incurred shall be apportioned in relation to time spent with each client. Out-of-pocket expenses shall not exceed Ten Thousand Two Hundred Fifty Dollars ($10,250.00) in the aggregate. CalOptima shall not pay CONTRACTOR for time spent traveling.

F. CONTRACTOR's fees for the goods and/or services provided under Exhibit A, Scope of Work, will be billed according to the following rates. These rates are fixed for the duration of the Contact.

1. Years 1-3:
   a. Audit of CalOptima Financials: $189,000
   b. Audit of MSSP: $16,000
   c. Maximum Obligation (Section D Above): $205,000
   d. Out-of-Pocket Expenses: $10,250

2. Year 4:
   a. Audit of CalOptima Financials: $194,150
   b. Audit of MSSP: $17,000

c.	Maximum Obligation (Section D Above):	$211,150
d.	Out-of-Pocket Expenses:	$10,557

3. Year 5:

a.	Audit of CalOptima Financials:	$200,000
b.	Audit of MSSP:	$17,484
c.	Maximum Obligation (Section D Above):	$217,484
d.	Out-of-Pocket Expenses:	$10,874

Exhibit B-1

Not applicable for this Contract

Exhibit C

CalOptima Travel Policy

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.5004		
Title:	**Travel Policy**		
Department:	Finance		
Section:	Purchasing		
CEO Approval:		Michael Schrader	MS
Effective Date:	8/1/12	Revised: 9/6/12, 3/1/13	
Board Approval:	9/6/12		

I. PURPOSE

To establish a process for reasonable and equitable reimbursement of approved travel and other related expenses incurred by CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants while traveling on authorized CalOptima Business.

II. POLICY

A. For the purpose of this policy, Individual shall mean, unless otherwise specified, all persons authorized to submit an Expense Report, including: CalOptima Board members, CalOptima Standing Committee members, CalOptima employees, and; individuals under contract to CalOptima for which the approved contract provides for reimbursement of travel and/or conference expenses, in accordance with CalOptima rules and regulations.

B. CalOptima shall provide an expense reimbursement process to ensure timely and accurate identification, approval, processing, recording, payment, and monitoring of all necessary travel expenses and miscellaneous expenses incurred by authorized Individuals, in accordance with generally accepted accounting principles (GAAP), and in compliance with State and Federal regulations.

C. CalOptima shall reimburse employees for reasonable expenses incurred while traveling on CalOptima business. All travel must be for the benefit of CalOptima, and must be completed at the most reasonable cost based on the facts and circumstances surrounding the travel. This includes making reservations for air travel and other expenses as soon as possible to access better rates. Employees are expected to use good judgment when traveling, seeking to minimize travel costs whenever possible.

1. Travel Expenses shall include the following items:

   a. Transportation: including commercial carriers, rental vehicles, and mileage for use of personal vehicle;

   b. Lodging;

   c. Meals;

   d. Registration Fees: For attending conferences, seminars, conventions, or meetings of professional societies or community organizations;

   e. Insurance for rental vehicles;

   f. Parking fees and tolls fees (i.e., toll roads and necessary parking);

g. Miscellaneous expenses including:

i. Authorized local and long-distance telephone calls;

ii. Baggage fees;

iii. Internet or Wi-Fi charges;

iv. Facsimiles;

v. Expenses in connection with the preparation of authorized company reports or correspondence;

vi. Taxi or public transit fares, required to conduct business; and

vii. Other unforeseen or unusual expenses that are properly justified and substantiated.

D. Board Member/Standing Committee Member Travel

1. CalOptima shall allow Board members and Standing Committee members reasonable and necessary Travel Expenses and miscellaneous expenses incurred when participating in activities as a member of their respective Board or Committee. Eligible Travel Expenses shall be governed by this policy.

a. The CEO or the Chairperson of the CalOptima Board of Directors, or his or her designee, shall review and approve all Board member and Standing Committee member non-local travel.

b. CalOptima shall limit Board member and Standing Committee member travel to the following purposes:

i. CalOptima business-related activities;

ii. Requests to represent CalOptima as a speaker at an approved meeting, seminar or conference; and

iii. Other travel deemed necessary by the CalOptima Board of Directors.

E. Travel Approval

1. Budgeted Travel: All budgeted Travel and miscellaneous expenses for CalOptima employees, Board members, Standing Committee members, and authorized contractors and consultants shall be pre-approved by the appropriate level of CalOptima Management or Board Chair, prior to travel expenses being incurred, according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

2. Non-Budgeted Travel: Non-Budgeted Travel and miscellaneous expenses for authorized Individuals shall be pre-approved by the CEO, or his or her designee, prior to Travel Expenses being incurred.

F. Conferences and Seminars

1. Attendance at any given conference and/or seminar shall be:

   a. Limited to the number of Individuals deemed appropriate by the CEO for that particular conference or seminar, and

   b. Approved by Human Resources.

2. Payment of Fees

   a. Conference and/or seminar fees shall be prepaid whenever possible, to take advantage of early registration discounts. An employee shall request prepayment of conference and seminar fees at the time the Travel and Training Authorization form is prepared, and submit necessary registration information to the Purchasing Department.

   b. In the event an Individual must personally pay for conference or seminar registration fees, the Individual shall request reimbursement on an Expense Report with a pre-approved Travel and Training Authorization Form.

G. Meal Expenses

1. Travel Meals are those food items consumed when traveling on CalOptima Business away from the primary workplace.

2. CalOptima shall reimburse authorized Individuals the actual cost of Travel Meals, excluding alcoholic beverages, in an amount not to exceed forty-five dollars ($45.00) per day, excluding taxes and gratuity.

   a. CalOptima shall reimburse employees and Board members for meals that exceed the forty-five dollars ($45.00) per day under the following conditions:

      i. The authorized Individual shall submit a valid receipt for such meals with a brief explanation of the expenditure. Individual meals shall be subject to the above limitations;

ii. The authorized Individual elects to pay for the meals of individuals with whom authorized CalOptima Business was conducted; or

iii. Extraordinary circumstances may cause it to be impractical or unfeasible for the authorized Individual to stay within the established meal rates, and the authorized Individual shall submit receipts for such meals with a brief explanation of the extraordinary expenditure.

iv. Expense reports containing extraordinary meal expenditures shall require approval of the CEO, or his or her designee.

b. CalOptima may negotiate individual meal per diem amounts for individual contractors authorized to receive reimbursement for expenses, as stipulated in this policy. Individual contractor per diem rates may be less than, but shall not exceed, the established employee, Board and Committee member meal reimbursement rate.

3. CalOptima shall reimburse for Business Meals at actual reasonable and necessary expenses for refreshments or meals, excluding alcoholic beverages, provided in conjunction with on-site or off-site meetings (e.g., in-house developed formal training sessions, conferences, seminars, workshops, staff meetings, and board and commission meetings) which extend over normal breaks or meal periods. An Expense Report for Business Meals must include receipt, names of those in attendance, and the business topic.

H. Lodging Expenses

1. CalOptima shall reimburse the cost of a single room at an Approved Lodging Facility for Non-Local Travel.

2. Adequate lodging expenses will be allowed. Price is an issue in selecting "adequate lodging". Prudence and good stewardship should be used when selecting a lodging facility. Comparison shopping is encouraged; booking through online travel Websites, as opposed to directly with the lodging facility, might provide opportunities for reduced cost lodging. Itemized receipts for lodging must be provided to obtain reimbursement.

3. Travelers should seek lodging rates (excluding taxes and fees) at or below the federal government's per diem rate. If such rates are not available, a hotel's discounted government rate shall be allowed. A schedule of federal lodging per diem rates is available on the U.S. General Services Administration (GSA) Website; www.gsa.gov.

4. CalOptima may reimburse additional lodging expenses for Non-Local Travel if:

a. It results in offsetting lower airfare; and

b. The cost of returning to home or office at the conclusion of business exceeds the cost of lodging, rental automobile and meals for the additional stay.

5. Local Travel may qualify for an overnight stay, depending on time constraints. CalOptima may approve Local Travel lodging expenses if:

a. It is not practical or feasible for the authorized Individual to return home due to extremely poor weather conditions; or

b. Less than eight (8) hours will elapse from the time business is concluded on one (1) day and the time business is scheduled to reconvene on the following calendar day; or

c. It is not practical or feasible for the authorized Individual to return home due to an extended commute.

6. Once approved, the Individual or his or her designee shall be responsible for making his or her own travel and lodging arrangements, utilizing the CalOptima travel services provider or another method approved by CalOptima's Purchasing Department.

7. The Individual shall be responsible for necessary cancellation of travel and lodging reservations, in accordance with the respective rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any cancellations.

I. Cash advances

1. Under normal circumstances, CalOptima shall not issue cash advances for Travel Expenses.

2. The Executive Management team shall approve cash advances for anticipated authorized travel.

3. CalOptima may authorize cash advances on a limited basis if the traveling Individual does not possess sufficient means of credit or other financial resources to cover the cost of one (1) or more authorized Travel Expenses, as defined in this policy.

4. When authorized, cash advances shall be based on an estimate of reasonable Travel Expenses, including travel, meals, lodging and miscellaneous expenses.

5. Individuals receiving cash advances shall complete an Expense Report within five (5) business days of the Individual's return to home or place of work, whichever occurs first. The Individual shall account for all expenses incurred while traveling on authorized CalOptima Business, and shall indicate any cash amounts due back to CalOptima, in the event the cash advance was greater than actual authorized expenses, or cash amounts due the Individual, in the event actual authorized expenses exceed the amount of the cash advance.

J. Transportation

1. The mode of transportation shall be based on the distance of the final destination from the Individual's home or primary workplace, business schedule, and the cost effectiveness of the various modes of transportation.

2. Cost of arrangements for personal travel in conjunction with a business travel itinerary will be at the authorized Individual's expense. The Individual shall document the incremental travel costs assessed to CalOptima, in accordance with this policy.

3. The Individual shall make transportation arrangements as far in advance as possible using the most economical carrier, and the most economical departure point, within the selected mode of transportation. A Saturday night stay may be required to obtain the lowest possible rate, and may be authorized if the savings will reasonably offset the additional cost of meals, automobile rental and lodging.

   a. Flight arrangements made through CalOptima's travel services provider shall be reviewed by CalOptima's Purchasing Department, and submitted directly to Accounts Payable for payment.

   b. Flight arrangements not made through the CalOptima travel services provider shall be submitted by the Individual on an Expense Report.

   c. Individuals may, for personal convenience, travel to their final destination on an indirect route, or on an interrupted direct route, if approved in advance by the CEO. An Individual shall pay any increase in transportation fares based on indirect or interrupted direct travel routes. Any resulting excess travel time shall not be considered work time, but shall be charged to the appropriate type of leave.

   d. Additional expenses shall not be the responsibility of the Individual if, through no fault or control of the Individual, it is necessary to travel an indirect route, or an interrupted direct route. In such cases, additional time shall be considered work time, and shall not be charged to any type of leave.

   e. Whenever available, all Individuals shall travel via "Coach Class," or similar reduced fare accommodations. "Business Class" reservations shall not be used except in the event that "Coach Class" or similar reduced fare accommodations are unavailable, and departure time is critical to the nature of the reason for travel. Under no circumstances shall "First Class" travel be reserved.

   f. Individuals requesting travel reservations shall not insist on any certain commercial carrier if using the specified carrier will result in a fare which is higher than the lowest available fare.

   g. Any deviation from lowest available rate for commercial carriers shall be at the Individual's expense.

4. The Individual shall be responsible for necessary cancellation of travel reservations, in accordance with the respective carrier rules and time limits. CalOptima shall not reimburse Individuals for fees associated with the failure to cancel reservations within the established carrier rules and time limits, unless the failure was due to circumstances beyond the control of the Individual. The Individual must also inform CalOptima's Purchasing Department of any such cancellations.

5. Use of Privately-Owned Vehicles

   a. An authorized Individual may use a privately-owned vehicle for travel if such use is more economical than the lowest-priced direct commercial carrier fare plus rental car expenses. The Individual must be licensed, and shall carry liability insurance as required by the State of California, at the Individual's sole expense.

b. CalOptima shall reimburse the use of privately-owned vehicles solely based on actual mileage at the Internal Revenue Service (IRS) Standard Mileage Rate. Total mileage reimbursed should consider the Individual's daily commute.

c. CalOptima shall not reimburse costs for fuel, automobile repairs, or other automobile expense items.

d. If more than one authorized Individual is traveling for CalOptima Business in the same personal vehicle, only one person shall be reimbursed for the use of a privately-owned vehicle.

e. Travel shall be by the most practical direct route. Any person traveling by an indirect route shall assume any additional expense incurred.

f. CalOptima shall compensate property damages to an Individual's automobile incurred without fault or cause on the part of the Individual up to two hundred fifty dollars ($250), or the amount of the deductible on the Individual's insurance policy, whichever is the lesser amount, for each accident.

6. Rental Automobiles

a. An Individual may rent automobile when such rental is considered to be more advantageous to CalOptima than other means of transportation.

b. Advance reservations shall be made whenever possible. Reservations for employees, Board and Committee members shall be made in the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

c. The vehicle rental agreement for the authorized Individual shall reference the Individual's name, acting for CalOptima. i.e., John Doe, for CalOptima.

d. Rental automobile approved classes are as follows:

i. Economy Class: An Individual shall select an economy class vehicle whenever four (4) or fewer individuals, including the driver, will be passengers in the rental automobile at any one time.

ii. Mid-size Class: An Individual may select a mid-size class vehicle in the event more than four (4) individuals will be riding in the rental automobile at any one (1) time, or in the event an economy class vehicle is not available, and the nature of the travel requires immediate departure.

iii. Luxury Class: Under no circumstances shall an Individual select a luxury class vehicle.

7. Other Modes of Transportation

a. Taxi Fares: CalOptima shall reimburse taxi fares when public transportation is not practical or available. Examples include travel between hotel and place of business, and from one business to another.

III. PROCEDURE

A. Travel and Training Authorization Form

1. Shall be accessed and completed on-line by all Individuals or their designee using CalOptima's Intranet system (or similar system in place at the time request is made), and shall include all actual or estimated expense amounts related to the request; and

2. Shall be routed for approval systemically based on the Individual's level, cost center, and whether they are a CalOptima employee according to the following:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee
CEO	Board Chairperson or designee
Board Member/Standing Committee Member	Board Chairperson, CEO or designee

3. Shall also be routed systemically to the Human Resources Department in order to track the Individual's training.

4. Shall also be routed systemically to the Finance Department for confirmation that requested expenses are budgeted, and that enough budget remains to cover requested expenses.

5. Requestors shall receive an automatic e-mail after submitting their request, notifying them of the approval status, and providing a link to the electronic form to track approval progress.

6. The Purchasing Department shall review, authorize for appropriate approvals, and notify the requestors that they may begin making travel commitments.

B. Travel and Training Arrangements

1. Authorizations that include event registration fees shall be pre-paid and processed by CalOptima's Purchasing Department, where possible. CalOptima's Purchasing Department shall verify with the requestor that the registration has not been processed before proceeding with registration of the Individual for the event.

2. The requestor, or his or her designee, shall make air travel arrangements through CalOptima's travel services provider, where possible. Arrangements should be made as far in advance as possible to minimize costs. Exceptions to using CalOptima's travel services provider are subject to approval by CalOptima's Purchasing Department.

3. All other arrangements shall be made with the Individual's personal credit card, either through CalOptima's travel services provider, another approved method, or directly with the establishment(s), subject to CalOptima's Purchasing Department approval.

C. Expense Reimbursement using Expense Report

1. Individuals or designees shall prepare and submit request claims for reimbursement of Travel Expenses on a CalOptima Expense Report. The report shall be completed by the Individual or designee, including all details, and shall be routed with a copy of the previously-approved Travel and Training Authorization Form for appropriate Expense Report approval signatures, if applicable, as follows:

Individual	Approver
Employee through Department Manager	Department Director
Department Director	Executive Management
Executive Officer	CEO or designee*
CEO	Board Chairperson or designee*
Board Member/Standing Committee Member	Board Chairperson, CEO or designee*

*Designee authorization is not valid when self approval would result.

2. Receipts

   a. For any expenses in excess of twenty-five dollars ($25.00), the Individual shall include an original credit card receipt, if available, or other computer-generated or hand-written receipt, in the event a credit card receipt is unavailable. CalOptima contractors authorized to receive reimbursement for expenses shall submit receipts for all expenses, regardless of the dollar amount of the expenditure.

   b. Small receipts, such as credit card, gas and airline receipts, shall be attached to an 8 ½ by 11 inch sheet of paper. Hotel receipts and other larger receipts may be submitted as is.

   c. In the absence of credit card receipts, or other proof of actual expenditure, CalOptima shall reimburse lodging expenses only if marked "paid" by the management of the lodging facility.

   d. In most instances, airfare for CalOptima employees and Board members shall be prepaid by CalOptima. CalOptima contractors authorized to receive reimbursement for airfare, and employees and Board members for whom airfare was not prepaid for any reason, shall submit passenger receipts for reimbursement consideration.

   e. If receipts cannot be obtained or have been lost, a statement to that effect shall be made on the Expense Report, along with an appropriate explanation. In the absence of a satisfactory explanation, CalOptima shall not allow the amount.

3. Completed and approved Expense Reports and supporting documentation shall be submitted to the Accounting Department in a timely manner, preferably within thirty (30) days of completion of travel.

4. No reimbursement shall be made for Expense Reports submitted beyond six (6) months after completion of travel.

D. The Accounting Department shall:

1. Review submitted Expense Reports and supporting documentation for completeness;

2. Code expenses to appropriate department and general ledger account numbers; and

3. Process payment for reimbursement.

E. The Purchasing Department shall:

1. Provide travel reports to the CEO, Executive Management, and Department Directors, upon request. Such reports may include a summary of travel by department, purpose, cost, and number of individuals per event, and may be required to distinguish between budgeted and non-budgeted travel.

2. Review details of statements/invoices received from the CalOptima travel services provider for accuracy and reasonableness;

3. Attach appropriate copies of completed Travel and Training Authorization Forms related to travel service provider invoice line items, and submit to Accounts Payable for payment.

4. Review details of statements/invoices received from credit card account used by Purchasing to arrange attendance at conferences, training, and other events, and to make authorized purchases.

5. Attach appropriate copies of completed Travel and Training Authorization Forms related to credit card invoice travel and training line items, and submit to Accounts Payable for payment.

IV. ATTACHMENTS

A. Electronic Travel and Training Authorization Form
B. CalOptima Expense Report
C. Cash Advance Form

V. REFERENCES

A. Internal Revenue Service Publication 463
B. California Government Code Section 53232.2
C. Bylaws of Orange County Health Authority dba Orange Prevention and Treatment Integrated Medical Assistance, Adopted December 6, 1994

VI. APPROVALS OR BOARD ACTION

9/6/12: CalOptima Regular Board Meeting

VII. REVISION HISTORY

A. 9/6/12: GA.5004: Travel Policy
B. 8/1/12: GA.5004: Travel Policy

VIII. KEYWORDS

Approved Lodging
CalOptima Business
Executive Management

Expense Report
Individual
Local Travel
Lodging
Meals
Miscellaneous Expenses
Non-Local Travel
Non-Reimbursable Expenses
Parking, Fees and Tolls
Registration Fees
Reimbursable Expenses
Transportation
Travel
Travel and Training Authorization Form
Travel Expenses

Exhibit D

MEDI-CAL DATA ACCESS AGREEMENT

As a condition of obtaining access to information concerning procedures or other data records utilized/maintained by the Department of Health Care Services and CalOptima, MOSS ADAMS LLP, including any and all individual employees and agents, agrees not to divulge any information obtained in the course of completion of this Contract to any unauthorized persons.

CONTRACTOR further agrees not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

CONTRACTOR further recognizes that unauthorized release of confidential information may be subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

CONTRACTOR further agrees that this Medi-Cal Data Access Agreement shall remain in full force and effect after the termination of this Contract.

By: Stacy J. Stelzriede Date: 2/16/2022

Print Name: Stacy J. Stelzriede

Title: Partner

Exhibit E
Part 1

STATE OF CALIFORNIA
DEPARTMENT OF HEALTH CARE SERVICES
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that :

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, "Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

MOSS ADAMS LLP
Name of Contractor

Stacy J. Stelzriede
Printed Name of Person Signing for Contractor

22-10461
Contract/Grant Number

Stacy J. Stelzriede
Signature of Person Signing for Contractor

2/16/2022
Date

Partner
Title

After execution by or on behalf of Contractor, please return to:

Department of Health Care Services
Medi-Cal Managed Care Division
MS 4415, 1501 Capitol Avenue, Suite 71.4001
P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit E

Part 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB 0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: ☐a. contract ☐b. grant ☐c. cooperative agreement ☐d. loan ☐e. loan guarantee ☐f. loan insurance	2. Status of Federal Action: ☐a. bid/offer/application ☐b. initial award ☐c. post-award	3. Report Type: ☐a. initial filing ☐b. material change **For Material Change Only:** Year _____ quarter_____ date of last report _____

4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ____, *if known*: Congressional District, *if known*:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, *if known*:
6. Federal Department/Agency:	7. Federal Program Name/Description: CDFA Number, *if applicable*:
8. Federal Action Number, *if known*:	9. Award Amount, *if known*: $_____
10. a. Name and Address of Lobbying Entity (*If individual, last name, first name, MI*): *(attach Continuation Sheet(s) SF-LLLA, if necessary)*	b. Name and Address of Lobbying Entity (If individual, last name, first name, MI):
11. Amount of Payment (check all that apply): $_____ ☐actual ☐planned	13. Type of Payment ☐ a. retainer ☐ b. one-time fee ☐ c. commission ☐ d. contingent fee ☐ e. deferred ☐ f. other, specify: _____
12. Form of Payment (check all that apply): ☐ a. cash ☐ b. in-kind, specify: Nature _____ Value _____	

14. Brief Description of Services Performed or to be Performed and Dates(s) of Service, Including Officer(s), Employee(s), or Member(s) Contracted for Payment indicated in Item 11:

(Attach Continuation Sheet(s) SF-LLL-A, If necessary)

15. Continuation Sheet(s) SF-LLL-A Attached: ☐Yes ☐No

16. Information requested through this form is authorized by Title 31, U.S.C., Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to Title 31, U.S.C., Section 1352. This information will be reported to the Congress semiannually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	Signature: Print Name: Title: Telephone No.: Date:

Federal Use Only | Authorized for Local Reproduction Standard Form-LLL

Rev. 07/2014 **Contract No. 22-10461**

Back to Item Back to Agenda

Exhibit E

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime federal recipients at the initiation or receipt of a covered federal action, or a material change to a previous filing, pursuant to Title 31, U.S.C., Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity 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 a covered federal action. Use the SF - LLL- A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered federal action.
2. Identify the status of the covered federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered federal action.
4. Enter the full name, address, city, state, and ZIP code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants, and contract awards under grants.
5. If the organization filing the report in Item 4 checks "Subawardee," then enter the full name, address, city, state, and ZIP code of the prime federal recipient. Include Congressional District, if known.
6. Enter the name of the federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation United States Coast Guard.
7. Enter the federal program name or description for the covered federal action (Item 1). If known, enter the full Catalog of Federal Domestic Assistance (CDFA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate federal identifying number available for the federal action identified in Item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract grant, or loan award number; the application/proposal control number assigned by the federal agency). Include prefixes, e.g., "RFP-DE-90401."
9. For a covered federal action where there has been an award or loan commitment by the federal agency, enter the federal amount of the award/loan commitment for the prime entity identified in Item 4 or 5.
10. (a) Enter the full name, address, city, state, and ZIP code of the lobbying entity engaged by the reporting entity identified in Item 4 to influence the covered federal action.

    (b) Enter the full names of the Individual(s) performing services and include full address if different from 10.(a). Enter last name, first name, and middle initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (Item 4) to the lobbying entity (Item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.
12. Check the appropriate box(es). Check all boxes that apply. If payment is made through an in-kind contribution, specify the nature and value of the in-kind payment.
13. Check the appropriate box(es). Check all boxes that apply. If other, specify nature.
14. Provide a specific and detailed description of the services that the lobbyist has performed, or will be expected to perform, and the date(s) of any services rendered. Include all preparatory and related activity, not just time spent in actual contact with federal officials. Identify the federal official(s) or employee(s) contacted or the officer(s), employee(s), or Member(s) of Congress that were contacted.
15. Check whether or not a SF-LLL-A Continuation Sheet(s) is attached.
16. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instruction, searching existing data sources, gathering and maintaining the data needed, and completing and renewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Office of Management and Budget, Paperwork Reduction Project, (0348-0046), Washington, DC 20503.

Exhibit F

Not applicable for this Contract

Exhibit G

ADDENDUM 1
MEDICARE ADVANTAGE PROGRAM

The following additional terms and conditions apply to the provision of goods or services to be utilized, directly or indirectly, by or for the Medicare Advantage Program. These terms and conditions are additive to those contained in the main Contract, and apply to the extent applicable to the services provided by CONTRACTOR. In the event that these terms and conditions conflict with those in the main Contract, these terms and conditions shall prevail.

A. In addition to compliance with the provisions of Section 8 in the Contract, CONTRACTOR expressly warrants that CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with all applicable Medicare laws, regulations, and CMS instructions. CONTRACTOR further agrees and acknowledges that this provision will be included in any and all agreements with CONTRACTOR's subcontractors.

B. For any medical records or other health and enrollment information CONTRACTOR maintains with respect to Medicare enrollees, CONTRACTOR shall establish procedures to:

1. Abide by all Federal and State laws regarding confidentiality and disclosure of medical records and other health and enrollment information. CONTRACTOR shall safeguard the privacy of any information that identifies a particular enrollee and shall have procedures that specify: (a) the purpose or purposes the information will be used within CONTRACTOR's organization; and (b) to whom and for what purpose CONTRACTOR will disclose the information.

2. Ensure that the medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

3. Maintain the records and information in an accurate and timely manner.

4. Ensure timely access by enrollees to the records and information that pertain to them.

C. CONTRACTOR shall comply with the reporting requirements provided in Title 42 of the Code of Federal Regulations, Section 422.516 as well as the encounter data submission requirements of 42 CFR Section 422.257.

D. For all contracts in the amount of $100,000 or more, in addition to the Equal Opportunity provisions included in the Contract, CONTRACTOR and CONTRACTOR's subcontractors, if any, shall comply with 41 CFR 60-300.5(a) and 41 CFR 60-741.5(a) as follows:

1. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-300.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED PROTECTED VETERANS, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED PROTECTED VETERANS.** (41 CFR 60-300.5(d).)

2. **THIS CONTRACTOR AND SUBCONTRACTOR SHALL ABIDE BY THE REQUIREMENTS OF 41 CFR 60-741.5(a). THIS REGULATION PROHIBITS DISCRIMINATION AGAINST QUALIFIED INDIVIDUALS ON THE BASIS OF DISABILITY, AND REQUIRES AFFIRMATIVE ACTION BY COVERED PRIME CONTRACTORS AND SUBCONTRACTORS TO EMPLOY AND ADVANCE IN EMPLOYMENT QUALIFIED INDIVIDUALS WITH DISABILITIES.** (41 CFR 60-741.5(d).)

E. In addition to the termination provisions of Section 16 of this Contract, CONTRACTOR agrees and acknowledges that CalOptima may terminate the Contract if CMS or CalOptima determines that

CONTRACTOR has not satisfactorily performed its obligations under the Contract. Under such circumstances, CalOptima may pay CONTRACTOR its allowable costs incurred to the date of termination. Thereafter, CONTRACTOR shall have no further claims against CalOptima for matters pertaining to this Contract.

F. While CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, CONTRACTOR shall comply with all such requirements at the direction of CalOptima.

G. CalOptima shall review, approve, and audit on an ongoing basis, the credentialing of medical professionals, if any, associated with CONTRACTOR and CONTRACTOR's performance of this Contract.

H. Notwithstanding the delegation by CalOptima to CONTRACTOR for the selection of providers, contractors, or subcontractors, CalOptima expressly retains the right to approve, suspend, or terminate any such arrangement.

I. Notwithstanding the written delegation by CalOptima to CONTRACTOR of any other activities under this Contract, CalOptima maintains ultimate responsibility for adhering to and complying with all terms and conditions of its contract with CMS, and expressly retains the right to approve, suspend, or terminate any such arrangement with CONTRACTOR. With all such delegated activities, CalOptima shall monitor CONTRACTOR's performance on an ongoing basis to ensure compliance with all applicable CalOptima and CMS requirements.

Exhibit H

CalOptima
Better. Together.

Attestation Concerning the Use of Offshore Subcontractors

If Organization offshores any protected health information (PHI) it must notify CalOptima prior to entering into or amending any agreement with an Offshore Subcontractor, and Contractor must complete the Offshore Subcontracting Attestation.

Which CalOptima program(s) does this form pertain to? Select all that apply.	☑ OneCare Connect ☑ PACE ☐ OneCare ☑ Medi-Cal

Please check one of the following:

☑ Our Organization does not offshore any protected health information.
Please skip to Part V below

☐ Our Organization does offshore protected health information.
Please complete Offshore Subcontractor Attestation (Part I through Part V) below

Part I — Offshore Subcontractor Information	
Attestation	**Response**
Our Organization uses an offshore subcontractor or offshore staff to perform functions that support our contract with CalOptima	☐ Yes ☐ No
Offshore Subcontractor name:	
Offshore Subcontractor country:	
Offshore Subcontractor address:	
Describe offshore subcontractor functions:	
Proposed or actual effective date for offshore subcontractor (MM/DD/Year):	

Part II — Precautions for Protected Health Information (PHI)	
Question	**Response**
1. Describe the PHI that will be provided to the offshore subcontractor	
2. Explain why providing PHI is necessary to accomplish the offshore subcontractor's objectives:	
3. Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III — Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract	
Attestation	**Response**
A. Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary protected health information (PHI) and other personal information remains secure.	☐Yes ☐No*
B. Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with CalOptima's contract with the offshore subcontractor.	☐Yes ☐No*
C. Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No*
D. Offshore subcontracting arrangement includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.)	☐Yes ☐No*

Part IV — Attestation of Audit Requirements to Ensure Protection of PHI	
Attestation	**Response**
A. Our Organization will conduct an annual audit of the offshore subcontractor/employee.	☐Yes ☐No*
B. Audit results will be used by our Organization to evaluate the continuation of its relationship with the offshore subcontractor/employee.	☐Yes ☐No*
C. Our Organization agrees to share offshore subcontractor's/employee's audit results with CalOptima or CMS upon request.	☐Yes ☐No*

***Explanation required for all "no" responses to Part III and Part IV above:**

Part V — Organization Information	
By signing below, I hereby attest that the information contained herein is true, correct and complete.	
Printed name of authorized person: Stacy J. Stelzriede	Title: Partner
Email: stacy.stelzriede@mossadams.com	Phone #: 949-474-2684
Signature: Stacy J. Stelzriede	Date: 2/16/2022

Note: CalOptima's policies and procedures, CMS training module instructions for FWA, General Compliance, General HIPAA, CalOptima's Code of Conduct, CalOptima's Compliance Plan can be accessed at https://www.caloptima.org/en/About/GeneralCompliance.aspx

Exhibit I

Officer, Owner, Shareholder, and Creditor Information

Contractor's Business Name: MOSS ADAMS LLP

Business Entity Type: PARTNERSHIP
(*Sole Proprietorship, Partnership, LLC, California Corporation, etc.*)

Business Address: 2040 MAIN STREET, SUITE 400

City: IRVINE State: CA Zip: 92614

Business Phone: 949-221-4000 Email: : STACY.STELZRIEDE@MOSSADAMS.COM

President: CHRIS SCHMIDT Contact Person: STACY J. STELZRIEDE

Person(s) Signing Contract & Title: : Stacy J. Stelzriede, Partner

*Please provide names of owners, officers, stockholders, and creditors of Contractor's business if such interest is over 5%. There are no owners, officers, stockholders and creditors with an interest in excess of 5%.

Name	Officer Title or Ownership/Creditorship %

BY SIGNING BELOW, THE UNDERSIGNED HEREBY CERTIFIES THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF HIS OR HER KNOWLEDGE AND BELIEF.

Stacy J. Stelzriede
Authorized Signature

2/16/2022
Date

Stacy J. Stelzriede, Partner
Name and Title

Exhibit J

Not applicable for this Contract

Exhibit K

Not applicable for this Contract

Exhibit L

Not applicable for this Contract

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
24. Authorize Insurance Policy Procurements and Renewals for Policy Year 2022-23

Contact
Nancy Huang, Chief Financial Officer, (657) 235-6935

Recommended Action
Authorize Procurement and Renewal of Insurance Policies for Policy Year (PY) 2022-23 at a premium cost not to exceed $4,250,000

Background/Discussion
CalOptima's business insurance coverage, except employee group health insurance and benefits, expires on April 7 of each year. Staff recommends renewing the same coverage categories included during PY 2021-22. As reference, the following table provides brief descriptions for the proposed insurance policies included for PY 2022-23:

Coverage Type	Description
Property	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location not due to an Earthquake. Property, General Liability, and Commercial Auto are collectively known as Commercial Package coverage.
General Liability (GL)	Provides coverage to third parties for bodily injury or property damage.
Commercial Auto	Provides coverage for bodily injury and property damage caused by CalOptima's company-owned van, as well as collision and comprehensive coverage for the van itself. Provides excess liability for employees using personal vehicles for company business.
Workers' Compensation (WC)/ Employers Liability (EL)	Provides coverage for medical care and temporary disability benefits to employees for on-the-job injuries or illnesses.
Umbrella	Provides excess limits for general liability and commercial auto coverage over and above the respective policies.
Earthquake	Provides coverage in the event of property or personal property damage to the 505 Building, the PACE center, and the Server location only due to an Earthquake.
Cyber – primary and excess	Provides coverage for claims related to or arising from cyber incidents, such as a data breach (coverage includes, but is not limited to, regulatory fines and penalties, business interruption, credit monitoring, notice requirements, etc.) or network extortion (e.g., ransomware).
Directors and Officers (D&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or breach of duty by a CalOptima employee or Board member when acting within his/her official capacity.
Employment Practices Liability (EPL) – primary and excess	Provides coverage for claims brought by any past, present or prospective employee against CalOptima or a CalOptima employee (acting within

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Coverage Type	Description
	the scope of his/her employment) alleging, for example, employment discrimination, harassment, or wrongful termination.
Crime	Provides coverage for claims related to employee theft or forgery of money, securities, or other property, and computer and funds transfer fraud.
Managed Care Errors and Omissions (E&O) – primary and excess	Provides coverage for claims that are a result of an act, error, or omission in the performance of CalOptima's managed care activities (e.g., provider contracting, utilization review, implementation of clinical guidelines).
Medical Malpractice (PACE)	Provides coverage for CalOptima employed physicians and certain other medical staff (i.e., CalOptima employed physician and therapists at the PACE center) in the event of a medical malpractice claim.
Pollution	Provides coverage for bodily injury, remediation expenses, and property damages to third parties and remediation expenses to CalOptima in the event of a pollution incident, such as stored paint leaching into the ground water supply.
Wage and Hour – primary and excess	Provides coverage for actual or alleged violations of the Fair Labor Standards Act or any similar federal, state, or local laws governing or related to the payment of wages.
Fiduciary	Provides coverage for actual or alleged mismanagement of CalOptima's employee benefit and retirement plans.

The following table provides information on the proposed coverage limits and deductibles for each type of insurance coverage:

Coverage	Limit	Deductible
Property	Building: $68,515,300	$10,000
	Business Personal Property: $30,431,278	$10,000
	Business Interruption & Extra Expense: $33,676,816	24 Hours
GL	GL: $1,000,000/$2,000,000 Employee Benefits Liability: $1,000,000	$25,000/$1,000
Commercial Auto	Auto Liability: $1,000,000 CSL	$0 Liability $1,000/$1,000 Damage
WC/ EL	WC: Statutory EL: $1,000,000/$1,000,000/$1,000,000	$0 (Guaranteed Cost)
Umbrella	$25,000,000	Primary limits for GL, Auto and EL

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Coverage	Limit	Deductible
Earthquake	$75,000,000	Earthquake 5% subject to $50,000 minimum per occurrence
Cyber – primary	$10,000,000 (TBD)	$1,000,000
Cyber – excess	$10,000,000 (TBD)	Primary limit for Cyber
D&O/EPL – primary	$5,000,000 (Shared Limit)	$750,000/$1,000,000 Class Action
D&O/EPL – excess	$15,000,000	Primary limits for D&O/EPL
Crime	$5,000,000	$100,000
Managed Care E&O – primary	$10,000,000	$750,000/Additional 50% Co-insurance for Breach of Contract
Managed Care E&O – excess	$10,000,000	Primary limit for Managed Care E&O
Medical Malpractice (PACE)	$1,000,000/$3,000,000	$5,000
Pollution (3-year Policy Term)	$2,000,000/$4,000,000	$25,000
Wage and Hour – primary	$5,000,000	$1,000,000
Wage and Hour – excess	$5,000,000	Primary Limit for Wage and Hour
Fiduciary	$5,000,000	$25,000/$1,000,000 Class Action

On February 9, 2022, Woodruff Sawyer, CalOptima's insurance broker, provided quotations for existing coverage. Staff has reviewed and evaluated the options. Overall, CalOptima's insurance policy renewals for PY 2022-23 are approximately 34% or $1,007,652 higher than the previous year. Staff recommends the following renewals at a total estimated premium not to exceed $4,250,000:

Coverage	2021-22 Premium	2022-23 Premium	$ Difference from Prior Year	% Difference from Prior Year
Renewal Premiums				
Commercial Package	$70,477	$71,792	$1,315	1.9%
WC/ EL	$970,211	$1,178,550	$208,339	21.5%
Umbrella	$35,601	$35,067	($534)	-1.5%
Earthquake	$215,814	$232,293	$16,479	7.6%
Cyber – primary	$145,613	$419,188*	$273,575	187.9%
Cyber – excess	$95,865	$322,113*	$226,248	236.0%
D&O/EPL – primary, Crime	$209,153 (D&O/EPL) $26,376	$251,317 (D&O/EPL) $29,024	$44,812	19.0%

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Coverage	2021-22 Premium	2022-23 Premium	$ Difference from Prior Year	% Difference from Prior Year
	(Crime)	(Crime)		
D&O/EPL – excess	$313,225	$368,707	$55,482	17.7%
Managed Care E&O – primary	$318,648	$374,164	$55,516	17.4%
Managed Care E&O – excess	$186,855	$224,498	$37,643	20.1%
Medical Malpractice (PACE)	$32,600	$52,833*	$20,233	62.1%
Pollution (3-year Policy Term)	$5,295	$5,295	$0	0.0%
Wage and Hour – primary and excess	$262,628	$315,876	$53,248	20.3%
Fiduciary	$38,549	$53,846	$15,297	39.7%
Total: Renewal Premiums	**$2,926,910**	**$3,934,562**	**$1,007,652**	**34.4%**

*Estimated Premium; carriers will not quote until 30 days from renewal date

Due to CalOptima's use of an insurance broker and the inherent competitive quotation process, negotiations may often continue up to the day before policy expiration. As of February 9, 2022, the Cyber – primary and excess and Medical Malpractice (PACE) coverage policy terms and premiums are still being discussed with the carriers.

Explanation of significant (i.e., at least 15%) cost increases:

- **WC/ EL:** CalOptima's premium increased by 22% or $208,339 from the previous year. The primary factor is due to an estimated 13% increase in payroll, which is the main driver of premium growth. In addition, CalOptima continues to experience a high frequency of ergonomic injuries, such as strains. The experience modifier increased 8 basis points year-over-year, from 183 to 191.

- **Cyber – primary and excess**: CalOptima's primary Cyber premium is expected to increase by at least 188% or $273,575 from the previous year, and the deductible will increase from $500,000 to $1,000,000, the lowest deductible that carriers are now quoting for a company CalOptima's size. One driver of the premium increase is the growth in Protected Health Information (PHI) and Personally Identifiable Information (PII) records and revenue at CalOptima, due to the year-over-year increase in membership. In general, ransomware and regulatory changes are driving increases in the frequency and severity of claims for carriers, resulting in increased premiums, tightening terms, and very cautious underwriting, especially for healthcare-related companies. Capacity of $10,000,000 primary will be tough to retain, as carriers are limiting their risk exposure; a more likely scenario is $5,000,000 primary and $10,000,000 excess limits, for a total limit of $15,000,000. As the excess coverage follows the primary coverage, its market is facing similar trends. As such, the excess coverage premium is expected to increase by at least 236% or $226,248 from the previous year. Both carriers have indicated to CalOptima's broker that because the market is so volatile, they will not provide a firm quote until 30 days from renewal date (i.e., March 8, 2022). As such, premiums could increase even more by then.

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- **D&O/EPL – primary and excess, Crime:** CalOptima's primary D&O/EPL and Crime premium increased by 19% or $44,812 from the previous year, with the deductible increasing from $500,000 to $750,000; limits remain at expiring levels. This is the most viable option for full coverage, as other carriers declined to quote or proposed higher deductibles and/or higher premiums. This continues to be the current trend in the EPL market, particularly in California and notably in Southern California, where elevated litigation frequency and increasing severity are causing carriers to limit their risk exposure by increasing premiums, increasing retention, lowering coverage limits, or implementing a combination of these actions. In addition, litigation for EPL claims nationwide continue to rise as companies resume and expand operations amidst COVID-19 restrictions and requirements (e.g., proof of vaccination, COVID-19 testing) and the focus on diversity, equity, and inclusion (e.g., unequal compensation).

  As the excess coverage follows the primary coverage, its market is facing similar trends. As such, the excess coverage premium also increased. Excess carriers are looking to shed risk, and those willing to keep it, like the incumbent carriers, are raising premiums significantly.

- **Managed Care E&O – primary and excess:** CalOptima's primary E&O premium increased by 17% or $55,516 from the previous year, and the deductible increased from $250,000 to $750,000. Breach of contract cases, which represent the main types of cases at CalOptima, continue to be subject to 50% co-insurance. These changes are driven by CalOptima's high claims activity.

  As the excess coverage follows the primary coverage, its market is facing the similar trends. As such, the excess coverage premium also increased. An option for consideration is to remove the excess E&O liability entirely. CalOptima is not susceptible to normal claims, such as class action for claims denials, or inappropriate underwriting, as a public government entity. Most other County Organized Health System (COHS) plans do not carry the excess coverage. The broker agrees that CalOptima could remove this coverage without much impact to risk exposure, at a premium savings of $225,000.

- **Medical Malpractice (PACE):** CalOptima's premium increased by 62% or $20,233 from the previous year. This is primarily due to increased exposure, with an uptick in services expected for the upcoming policy year. A competitive quote was received from another carrier, for a premium savings of $12,500, but the terms and conditions are not as favorable as the incumbent policy. Staff continues to work with the broker to negotiate better terms in the competitive quote.

- **Wage and Hour – primary and excess:** CalOptima's premium increased by 20% or $53,248 from the previous year. This is mainly due to market loss trends experienced by the small number of offshore carriers offering this type of coverage.

- **Fiduciary:** CalOptima's premium increased by 40% or $15,297 from the previous year. This is mainly due to an increase in aggregate plan assets. Excessive litigation in recent years regarding plan fees have caused carriers to increase premiums to cover case settlements.

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Fiscal Impact

The recommended action to procure and renew insurance policies for PY 2022-23 for the period of April 7, 2022, through June 30, 2022, is a budgeted item under the Fiscal Year (FY) 2021-22 Operating Budget. Management plans to include funding for the remaining policy period of July 1, 2022, through April 6, 2023, and projected expenditures through fiscal year end in the CalOptima FY 2022-23 Operating Budget.

Rationale for Recommendation

The continued procurement of business insurance, without a lapse in coverage, ensures that CalOptima's risk and exposure to claims is mitigated as much as possible.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachments

1. Contracted Entities Covered by this Recommended Board Action

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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CONTRACTED ENTITIES COVERED BY THIS RECOMMENDED BOARD ACTION

Name	Address	City	State	Zip Code
Argo Re	110 Pitts Bay Rd	Pembroke HM 08	Bermuda	
AWAC	199 Water St, 25th Floor	New York	NY	10038
Beazley US /Lloyds	30 Batterson Park Rd	Farmington	CT	06032
CNA	151 North Franklin St	Chicago	IL	60606
Ironshore	28 Liberty St, 5th Floor	New York	NY	10005
Navigators/Hartford	83 Wooster Heights Road	Danbury	CT	06810
QBE	55 Water Street	New York	NY	10041
RT Specialty	180 N Stetson Ave, Ste 4600	Chicago	IL	60601
TDCSU	29 Mill Street	Unionville	CT	06085
Woodruff-Sawyer & Co.	50 California Street, Floor 12	San Francisco	CA	94111
XL	70 Seaview Avenue	Stamford	CT	06902

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2022
Regular Meeting of the CalOptima Board of Directors

Report Item
25. Authorize Formation of the CalOptima Foundation

Contacts
Michael Hunn, Chief Executive Officer, Interim, (657) 900-1481
Yunkyung Kim, Chief Operating Officer, (714) 246-8408

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to take the administrative steps necessary to form the CalOptima Foundation as a private non-profit entity under section 501(c)(3) of the Internal Revenue Code.

Background and Discussion
Staff request to initiate the formation of the CalOptima Foundation. The purpose of the CalOptima Foundation will be to support the health of Orange County residents, especially those who are under-resourced. The specific purposes of the CalOptima Foundation will be to:

- Further the mission of CalOptima;
- Provide assistance and support to CalOptima programs and members;
- Make contributions, grants, gifts and transfers of property, for the benefit of CalOptima; and
- Receive and accept contributions, grants, gifts and transfers of property in accordance with applicable laws and regulations governing CalOptima.

The formation of a foundation is not new to CalOptima. CalOptima's previous foundation was incorporated in 2010 as a 501(c)(3) nonprofit charitable organization to assist in performing the functions and carrying out the programs of CalOptima. That foundation's primary activity centered around the administration of a federal grant to support implementation of electronic health record systems in Orange County. Following the completion of that federal grant, the CalOptima Board of Directors approved funding of community grants through the foundation. In 2018 the Board of Directors dissolved the foundation. The rationale was that the foundation had no significant activity since 2015, and community health benefit activities such as grant making could be conducted from the plan.

Staff believe that with the current Medi-Cal program and California Advancing Innovation in Medi-Cal (CalAIM), a foundation separate from the health plan will provide opportunities for CalOptima to further its mission and benefits to the Orange County community.

At this time, staff seek the Board's approval to take administrative steps to form the CalOptima Foundation. Such administrative steps would include the filing of articles of incorporation, submitting applications for federal and state tax exemption, and other document preparation to form and maintain a 501(c)(3) entity.

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Staff will return to the board to request approval for subsequent actions to finalize and operationalize the CalOptima Foundation, including but not limited to, appointment of the CalOptima Foundation board of directors, approval of the CalOptima Foundation bylaws, appointment of staff, and budget action.

Fiscal Impact

The formation of the CalOptima Foundation will have no direct fiscal impact on CalOptima. The CalOptima Foundation budget will be developed separately once the initial formation is complete. Consistent with the requirements of the Internal Revenue Code, the financial results of the CalOptima Foundation will be segregated from those of CalOptima.

Rationale for Recommendation

The formation of the CalOptima Foundation will provide CalOptima with greater opportunities to further its mission and serve its programs and members. The requested action will initiate the formation of the CalOptima Foundation.

Concurrence

James Novello, Outside General Counsel, Kennaday Leavitt

Attachment

1. Previous Board Action, dated December 6, 2018, "Acting as the CalOptima Foundation, Consider Authorization of Actions Related to the Dissolution of the CalOptima Foundation and Disposition of Remaining CalOptima Foundation Assets"

/s/ Michael Hunn *02/24/2022*
Authorized Signature **Date**

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CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

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

Report Item

17. **Acting as the CalOptima Foundation**, Consider Authorization of Actions Related to the Dissolution of the CalOptima Foundation and Disposition of Remaining CalOptima Foundation Assets

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400
Cheryl Meronk, Director, Strategic Development, (714) 246-8400

Recommended Actions

1. Approve Dissolution of the CalOptima Foundation, with the assistance of Legal Counsel, and authorize the Executive Director to complete a Certificate of Election to Wind Up and Dissolve and a Certificate of Dissolution.
2. Authorize the Executive Director, with the assistance of Legal Counsel, to execute any other actions, as necessary to dissolve the CalOptima Foundation.
3. Authorize the Executive Director to return the remaining assets back to CalOptima following completion of dissolution, less necessary costs of wind up and dissolution, if any.

Background

In 2010, the CalOptima Foundation (the Foundation) was incorporated as a 50l(c)(3) nonprofit charitable organization. The specific purpose for which the Foundation was incorporated is "to assist in performing the functions and carrying out the programs of CalOptima." The initial focus of the Foundation was to apply for federal grant funding to operate the CalOptima Regional Extension Center (COREC), which was designed to support implementation of electronic health record systems in provider offices. To date, the Foundation's activities centered around the administration of the approximately $6.7 million federal COREC grant.

Near the Foundation's inception, it entered into an administrative services agreement with CalOptima under which CalOptima would provide certain administrative and technical services in exchange for payment from the Foundation.

Shortly after the Foundation's establishment, the CalOptima Board of Directors undertook a strategic planning process focused on unmet needs in the community impacting the health of CalOptima's members. To address those needs, CalOptima's Board approved the 2013–16 Strategic Plan, aimed in part at providing support for expanding the Foundation.

In March 2014, the CalOptima Board authorized a one-time $3 million transfer to the Foundation from CalOptima's net assets in the Fiscal Year (FY) 2013-14 budget. An expenditure plan was approved a few months later, stating that the intent was to use those transferred dollars for these primary purposes:

- Sustaining and expanding COREC activities ($1.2 million);
- Community health grants to strengthen the safety net, enhance preventative services and support wraparound services for CalOptima members ($1.5 million); and

- Administrative expenses ($300,000).

The original federal COREC funds were largely exhausted in Fall 2015. As part of the COREC grant, a deliverable included a sustainability plan. CalOptima was interested in pursuing a continuation and extension of COREC services in part because of this sustainability plan requirement. Separate and apart from the Foundation, CalOptima (the public agency) subsequently applied for and was awarded a separate $4.3 million state grant. (The state grant did not require a 501(c)(3) nonprofit charitable organization to apply for the funds.)

CalOptima, the public agency, began directly administering the newly-named electronic health record project, CalOptima Technical Assistance Program (COTAP). With the exhaustion of the original COREC federal grant made to the Foundation, the Foundation is not involved in the COTAP project activities.

At this stage, the majority of $3 million in funds transferred from CalOptima to the Foundation remain unexpended, with a balance of approximately $2.8 million, as of September 2018.

Discussion

Amid the shift from COREC to COTAP and anticipating the need to address the status and future of the Foundation, the CalOptima Board (acting as the Foundation Board) suggested further discussion via the formation of an Ad Hoc committee that met on July 7, 2015, to review the following:

- The purpose for creation of the Foundation;
- Activities of the Foundation;
- Approval of transferring funds from CalOptima (the public agency);
- Impacts and consequences of continuing the Foundation; and
- Comparison with other public health plan Foundation or community benefit programs.

The Ad Hoc committee requested further study in several areas. CalOptima staff researched the topics and provided the following information:

- An organization either is *or* is not qualified under Internal Revenue Code section 501(c)(3) for tax exemption; there is no "inactive" status.
- An organization with 501(c)(3) status may exist indefinitely without conducting any of the activities related to the purpose for which it was created, if administrative duties, such as filing tax returns and other state filings are completed. An exempt organization may be suspended and have its tax exemption revoked for not conducting these administrative functions and filing proper documents.
- The administrative cost to maintain exempt status for the Foundation is nominal. Costs include the filling of the state and federal tax forms annually, the Attorney General's Registry of Charitable Trust form (RRF-1) annually, and the Secretary of State registration form (SI-100) every two years.
- The transfer of funds between two tax-exempt entities (CalOptima, the public agency, and CalOptima Foundation) does not generate any tax consequences.

Further discussion and action about the Foundation was postponed and a new CalOptima Board was appointed in July 2016.

At this stage, the COREC initiative has been completed. The Board of Directors requested an update on the status of the Foundation, which was provided at the November 1, 2018, CalOptima Board meeting. At that meeting, the Board directed staff to bring back a recommendation to wind down the Foundation and return any remaining assets after the costs associated with wind down, to CalOptima. Unexpended Foundation assets currently total approximately $2.8 million.

Alternatively, the Foundation Board could, for example, instead direct that the funds allocated to COREC and community health grants be allocated to fund community grants in alignment with the original Foundation expenditure plan to fund a community health grants program. Grants could be made as follows:

Community Grant Requests for Proposal (RFPs):

Grant RFP	Total Grant Award
1. Mental Health Services for Adults: Telehealth Implementation in FQHCs/Community Clinics	$1,500,000
2. Mental Health Socialization Services for Older Adults	$400,000
3. Mental Health/Developmental Services for Children	$400,000
4. Medi-Cal Benefits Education and Outreach	$400,000
Total Grant Funding:	$2,700,000

After grant funds are distributed, any remaining assets would be set aside to cover necessary costs of dissolution and associated activities, if any.

With almost no remaining assets, the Foundation staff may then begin a dissolution process, including compliance with the requirements of the California Secretary of State and Attorney General, and the additional steps as noted below, provided that there are no remaining tasks or reports that need to be completed under the original COREC grant.

The process of dissolving the Foundation may be initiated by a resolution of the Foundation Board. Some additional steps will be required, including, but not limited to:

- Filing a certificate of election to dissolve with the California Attorney General;
- Reviewing and retiring Foundation activities and policies, and distributing any other remaining assets;
- Filing a certificate of dissolution with Secretary of State;
- Filing a final dissolution packet with California Attorney General; and
- Filing final tax returns.

Fiscal Impact

The recommendations to authorize actions to dissolve the CalOptima Foundation has no material fiscal impact on CalOptima. The cost to wind up and dissolve the CalOptima Foundation are anticipated to be nominal (e.g., filing fees) and would be paid prior to the return of the remaining assets to CalOptima. Remaining assets from the CalOptima Foundation after costs of wind up and dissolution will be returned back to CalOptima.

Rationale for Recommendation

The CalOptima Foundation has had no significant activity conducted since 2015. Additional research demonstrated that most Medi-Cal health plans conduct community health benefit activities, such as grant making, directly from the plan, and do not have a separate foundation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: CalOptima Foundation: Recommendation
2. CalOptima Board Action dated March 6, 2014, Approve Proposed Work Plan for CalOptima Foundation and Approve Transfer of Fiscal Year 2013-14 Budget Allocation to CalOptima Foundation
3. CalOptima Foundation Board Action dated September 4, 2014, Authorize the Fiscal Year (FY) 2014-15 CalOptima Foundation Expenditure Plan

/s/ Michael Schrader — *11/28/2018*
Authorized Signature — **Date**

CalOptima Foundation:

Recommendations

CalOptima Board of Directors

December 6, 2018

Cheryl Meronk

Director, Strategic Development

Agenda

1. CalOptima Foundation Creation
2. Foundation Activities (COREC)
3. Ad Hoc Committee Key Questions and Answers
4. Foundation Current Status
5. Recommendations

CalOptima Foundation Creation

- CalOptima Foundation is a 501(c)(3) nonprofit corporation formed in 2010

- Foundation was created to apply for a one-time federal grant of $6.7 million to operate the CalOptima Regional Extension Center (COREC)
  - At the time, CalOptima (the public agency) was not eligible to receive the grant
  - Only 501(c)(3) corporations were eligible to apply for funding

Foundation Activities

- Since the Foundation's formation, activities have focused only on operation of COREC
- COREC assisted more than 1,200 Orange County primary care physicians with implementing electronic health record (EHR) systems
- Federal COREC funds were exhausted in Fall 2015

Foundation Activities, cont.

- September 2014: $3 million one-time transfer from CalOptima to the Foundation, for the following purposes:
  - $1.2 million for COREC expansion
    - Extended the program to include specialists
  - $1.8 million for community health grants
    - Strengthen the Safety Net
    - Enhance Preventative Services
    - Support for wrap-around services for CalOptima members
    - Support for administrative expenses
- June 2015: DHCS technical assistant grant made to CalOptima (not the Foundation)
  - $4.3 million awarded by the state for expansion of program related to electronic health records

Ad Hoc Committee – Background

- May 2015 - the CalOptima Board of Directors suggested further discussion as to the future and role of the CalOptima Foundation
  - Ad Hoc Committee was formed

- July 2015 - Ad Hoc committee members met and asked staff to conduct further research on questions relating to the Foundation

Ad Hoc Committee – Key Questions

1. What are the different categories/levels of 501(c)(3)? (e.g., can Foundations exist in inactive or active status)?

2. What are some of the estimated administrative costs to keep the 501(c)(3) non-profit charitable organizations in an inactive status (if applicable)?

3. If the Foundation is in an in-active status, how long (potentially) before the state could recommend closing down the non-profit organization?

4. Will there be any tax or legal ramifications to CalOptima or the Foundation to transfer the $3M back to CalOptima?

Responses to Key Questions

1. An organization either is or is not qualified under 501 (c)(3) for a tax exemption; there is no “inactive” status

2. An organization with 501 (c)(3) status can exist indefinitely without conducting any of the purpose for which it was created

3. The administrative cost to maintain exempt status for the CalOptima Foundation is nominal. An organization can exist indefinitely as long as administrative duties, such as filing tax returns and other State filings are completed

4. The transfer of funds between two tax exempt entities (CalOptima the public agency and the CalOptima Foundation) does not generate any tax consequences

Foundation Status

- Currently an existing 501(c)(3), non-profit, charitable organization
- Approximately $2.8 million in Foundation balance
  - Majority of funds are unallocated
- Ongoing administrative costs to maintain 501(c)(3) status
  - Conduct annual financial audits
  - File for state and federal tax-exempt status (e.g., Form 990)
  - Submission of forms RRF-1 and SI-100
  - Use of staff time
- No activities/grant awards conducted

Recommendation

- Return unexpended funds, approximately $2.8 million to CalOptima (the public agency)
- Take steps to begin the process to dissolve the Foundation as noted, which include:
  - Filing a certificate of election to dissolve with the California Attorney General
  - Reviewing and retiring Foundation activities and policies, and distributing any other remaining assets
  - Filing a certificate of dissolution with Secretary of State
  - Filing a final dissolution packet with California Attorney General
  - Filing final tax returns

Alternative Recommendation

- Consider the use of Foundation funds allocated for COREC and community health grants to be used for community grants
  - CalOptima's Member Health Needs Assessment and Request for Information (RFI) responses have identified categories for community grants

- Any remaining assets after grant distribution would cover any cost of dissolving the Foundation and associated activities

Four Proposed Grant RFPs

RFP #	RFP Description	Funding Amount
1	Mental Health Services for Adults (Telehealth at FQHCs/Community Clinics)	$1.5 million
2	Mental Health and Socialization Services for Older Adults (65+ years)	$400,000
3	Mental Health/Developmental Services for Children 0–5	$400,000
4	Medi-Cal Benefits Education and Outreach	$400,000
	Total	**$2.7 million**

* Multiple awardees may be selected per RFP

RFP 1

Expand Access to Adult Mental Health Services Through Telehealth: FQHCs/Community Clinics

- **Funding Amount:** $1.5 million
- **Description:**
  - Provide mental health care services to adults ages 19–64 in a FQHC/community clinic setting via telehealth methods
  - Offer services including but not limited to:
    - Access to specialty mental health services such as psychiatry etc.
    - Multiple modes of telehealth, such as live video conferencing, telephone, etc.
    - Evaluation/assessments and treatment/counseling at more accessible days and times
    - Timely medication(s) prescribing
    - Appropriate training so qualified clinical/administrative staff can provide services

RFP 2

Expand Access to Older Adult Mental Health and Socialization Services

- **Funding Amount:** $400,000
- **Description:**
  - Provide community-based socialization services, focusing on Farsi- and Korean-speaking older adults, along with adults speaking other threshold languages
  - Offer resource referral, linkage and follow-up to ensure activities/services are successful, such as:
    - Educational and social activities (e.g., language classes)
    - Peer mentoring services (e.g., computer/technology classes)

RFP 3

Expand Access to Children's Mental Health/Developmental Services

- **Funding Amount:** $400,000
- **Description:**
  - Provide mental health services to children, ages 0–5, through partnership with mental health care professionals and early education staff
    - Increase access to early developmental and intervention screenings through trainings that enable additional qualified individuals to conduct screenings
    - Refer and/or provide direct access to therapies and/or interventions for children, families and other caregivers
    - Use a community-based health system navigator model to connect members to services

RFP 4

Medi-Cal Benefits Education and Outreach

- **Funding Amount:** $400,000
- **Description:**
  - Provide information about Medi-Cal benefits and coverage as well as information and assistance with annual renewal
  - Deliver services in a one-on-one and/or group setting
  - Use a health navigator model to assist members to access and connect to Medi-Cal services and other resources
  - Provide services in high-need and hard-to-reach ethnic communities speaking CalOptima threshold languages
  - Ensure health care navigators are easily accessible in the community

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken March ~~7~~ 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Approve Proposed Work Plan for CalOptima Foundation and Approve Transfer of Fiscal Year 2013-14 Budget Allocation to CalOptima Foundation

Contact

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

Recommended Actions

1. Approve proposed work plan for CalOptima Foundation; and
2. Approve transfer of a $3 million Fiscal Year 2013-14 budget allocation to the CalOptima Foundation.

Background

The CalOptima Foundation obtained 501(c)(3) designation in 2010 as part of a successful effort to seek Federal funding to operate the CalOptima Regional Extension Center (COREC). It is governed by the CalOptima Board, acting in its capacity as the Foundation Board an average of two to four times per year to conduct business relating to COREC and required annual functions (e.g., budget, audit). Currently, the Foundation's activities include the administration of the COREC grant which was awarded to CalOptima by the U.S. Department of Health and Human Services' Office of the National Coordinator to assist primary care physicians implement electronic medical record systems.

In conjunction with CalOptima's Board-approved 2013-16 Strategic Plan, expanding the function of the Foundation to complement the work of the health plan in better serving members is a strategic objective under the Financial Stability priority. The Fiscal Year 2013-14 budget includes a $3 Million set-aside for the Foundation.

Discussion

Current and planned Foundation activities include:

- Sustaining and expanding COREC services to increase meaningful use of electronic health records by primary and specialty care physicians serving Medi-Cal members;
- Transitioning current development and community-centered activities to the Foundation for greater plan efficiency, including:
    - Increasing provider capacity and incubating emerging programs or models that address unmet community needs;
    - Supporting community programs, such as community health promotion and Medi-Cal outreach and enrollment events;
- Pursuing federal and foundation grants and partnering with community groups on solutions to healthcare gaps.

A high-level work plan for Foundation expansion planning is included in the attached presentation. Staff recommends proceeding with implementation of the proposed work plan during the current fiscal year, with funding commitments consistent with the Foundation's filing status and available funding taking place in FY 2014-15.

Fiscal Impact
The recommended action would result in an estimated expenditure of $3 million for CalOptima Foundation which would be funded from CalOptima reserves as established in June 2013.

Rationale for Recommendation
Continuation and expansion of the CalOptima Foundation's functions to support activities that address service gaps experienced by CalOptima members and the community is consistent with the Board-approved 2013-16 Strategic Plan. These activities also complement current efforts to implement health information technology to improve delivery and coordination of care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *2/28/2014*
Authorized Signature — **Date**

CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 4, 2014
Meeting of the CalOptima Foundation Board of Directors

Report Item
VII. E. Authorize the Fiscal Year (FY) 2014-15 CalOptima Foundation Expenditure Plan

Contact
Michael Ruane, Executive Director, (714) 246-8400

Recommended Action
Authorize the FY 2014-15 CalOptima Foundation Expenditure Plan.

Background and Discussion

Foundation History and Role
The CalOptima Foundation (Foundation) obtained 501(c)(3) designation in 2010 as part of a successful effort to seek federal funding to operate the CalOptima Regional Extension Center (COREC). It is governed by the CalOptima Board, acting in its capacity as the Foundation Board an average of 2 to 4 times per year to conduct business and required annual functions (e.g., budget, audit). Currently, the Foundation's activities center on the administration of the COREC grant.

Foundation Expansion Planning
In conjunction with CalOptima's Board-approved 2013-16 Strategic Plan, expanding the function of the Foundation to complement the work of CalOptima the health plan in better serving members is a strategic objective under the Financial Stability priority. The Board-approved Fiscal Year 2014-15 CalOptima budget includes a $3 million set-aside for the Foundation.

In March 2014, CalOptima's Board approved a high-level work plan for Foundation expansion with funds allocated to two main categories: (1) the expansion of COREC services and (2) implementation of a Community Health Grant Program.

Extension of COREC Services – Approved Amount: $1.2 Million

The COREC grant was awarded to the CalOptima Foundation by the U.S. Department of Health & Human Services, Office of the National Coordinator for Health Information Technology, to assist Orange County healthcare providers with implementation of electronic health record (EHR) systems and attainment of meaningful use certification. Meaningful use refers to providers' ability to use EHR technology to improve quality, safety and efficiency.

Federal guidelines define three tiers of progressively more sophisticated meaningful use criteria, described generally as follows:

- Stage 1: Capture data and share internally
- Stage 2: Share information with multiple providers, including specialists and hospitals
- Stage 3: Show documented improvement in patient outcomes.

Consistent with these requirements, the COREC has worked with approximately 1,000 Orange County Primary Care Providers (PCPs) to achieve Stage 1 meaningful use and is assisting these providers with meeting Stage 2 criteria, which became more stringent in 2014. Many of these providers are requiring additional resources and technical assistance to meet the January 1, 2015 deadline for Stage 2 criteria and avoid a 1 percent cut to their Medicare reimbursement; this support is being funded through IGT funds.

With the approved Foundation funding, COREC will extend its services as follows:

- Provide meaningful use supports for 114 PCPs and 430 specialists (program is currently limited to PCPs);
- Improve health care access and delivery, for example through enhanced clinical data analytics and assisting providers in adopting telemedicine delivery models.

It is anticipated that the full $1.2 million allocation will be applied toward costs associated with assisting provider practices to select and implement an EHR system and achieve federal meaningful use criteria of the new technology. COREC staffing costs are excluded from the Foundation budget since they were previously included as part of the approved CalOptima Medi-Cal FY 2014-15 Operating Budget.

Community Health Grant Program – Approved Amount: $1.8 Million

At its March 2014 meeting, CalOptima's Board designated funding to invest in promising practices and approaches to address community needs and gaps. Some options to explore include:

- Strengthening the safety net, for example by enhancing community clinic capacity;
- Expanding access to and use of preventive services, such as developmental, vision and dental screening;
- Providing wraparound services and promoting integration of services for vulnerable populations, such as homeless members and foster children.

To provide further guidance, staff has convened a MAC/PAC ad hoc subcommittee to review available data and provide recommendations for grant-making priorities. The group is scheduled to complete its work in the September - October timeframe. CalOptima subject matter experts will then review the group's input and propose a final set of funding recommendations (with corresponding budget amounts) to the Board for consideration.

Proposed Budget
The proposed CalOptima Foundation FY 2014-15 Expenditure Plan is presented in the table below. This budget includes a line item for general and administrative expenses related to administration of Foundation business, which was not specifically carved out in the preliminary budget presented to the Board in March 2014. Staff recommends that $300,000 be moved from the Community Health Program allocation for this purpose.

In accordance with accepted practices in nonprofit management, the Foundation's administrative costs will not exceed 10% of the total operating budget, or $300,000, for FY 2014-15. Salaries and benefits for 2.0 FTEs are the main expenditure. During the start-up period these expenditures may be utilized to reimburse current staffing costs, supports and Foundation activities. The scope of work for the

proposed positions includes administering competitive grant processes for each of several funding priorities; developing agreements with grantees; monitoring grant performance; providing technical assistance to grantees; and reporting on grant outcomes.

Recommended FY 2014-15 CalOptima Foundation Expenditure Plan

	FY 2014-15 Budget
COREC:	
Professional fees for contracted service partners for technical assistance to PCPs and specialists	$1,200,000
Community Health Grant Program:	
Grants for select funding priorities	$1,500,000
Administrative Expenses:	
Salaries, Wages & Benefits	$210,000
Professional Fees	$50,000
Printing & Postage	$10,000
Other Operating Expenses	$30,000
Subtotal	$300,000
Total	$3,000,000

Fiscal Impact
The recommended action provides additional details on expenditures of the FY 2013-14 budget allocation of $3 million for the CalOptima Foundation, approved at the March 6, 2014 CalOptima Board meeting.

Rationale for Recommendation
Continuation and expansion of the CalOptima Foundation's functions to support activities that address service gaps experienced by CalOptima members and the community is consistent with the Board-approved 2013-16 Strategic Plan. These activities also complement current efforts to implement health information technology to improve delivery and coordination of care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

8/29/2014 — **Date**

Board of Directors Meeting
March 3, 2022

Special Joint Meeting of the Member Advisory Committee and the Provider Advisory Committee

Report to the Board

On February 10, 2021, the Member Advisory Committee (MAC), and the Provider Advisory Committee (PAC) held a special joint meeting to discuss topics of mutual interest.

Michael Hunn, Interim Chief Executive Officer (CEO), thanked the MAC and the PAC members for their service to the CalOptima members and reiterated CalOptima's motto of Better Together with the assistance of the Board Advisory Committees. Mr. Hunn also introduced Richard Pitts, M.D. as CalOptima's new Chief Medical Officer (CMO), and provided an update of items of mutual interest to the committees and discussed the upcoming vaccination site dates, the mobile mammography machines, and asked the committees to please spread the word among those they serve.

Yunkyung Kim, Chief Operating Officer (COO), told the committees that CalOptima would be transitioning provider newsletters and other items from fax to email and that staff was looking at ways to help transition all of CalOptima's communications to a more streamlined process. Ms. Kim also provided a Public Affairs update to the committee members.

Richard Pitts, D.O., Chief Medical Officer (CMO), introduced himself to the committees and provided an overview of his background. Dr. Pitts expressed his appreciation for the MAC and PAC and is looking forward to providing in-depth updates at future meetings.

Kristin Gericke, Director, Clinical Pharmacy, provided an update on the transition of Medi-Cal Rx to Magellan and the members of both MAC and PAC shared their experiences. Yunkyung Kim, COO provided the committees with an update on California Advancing and Innovating Medi-Cal (CalAIM) program roll-out. Marie Jeannis, Executive Director, Quality and Population Health Management, provided an overview of the Draft Department of Health Care Services 2022 Comprehensive Quality Strategy.

The MAC and PAC Chairs both announced that the committees will begin their recruitment process on March 1, 2022.

The members of the MAC and PAC appreciate the opportunity to update the Board on their current activities.

Back to Agenda